THE CURRENT STATUS OF MARRIAGE AND FAMILY THERAPISTS' GRADUATE TRAINING IN THE IDENTIFICATION, ASSESSMENT, AND TREATMENT OF RELATIONSHIP VIOLENCE

By

MARIE T. BRACCIALE

A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2004

ACKNOWLEDGMENTS

The author acknowledges the entire faculty in the Counselor Education Department for preparing me to do this research. I am most appreciative of Dr. Silvia Echevarria-Doan, chair, and my online editor, Dr. Jerry Byrd, for their many suggestions during discussions and editing sessions. My thanks go to Dr. Birnbaum of California State University, Fullerton, who developed the SurveyWiz program for the behavioral sciences, made it accessible to me, and gave me permission to use it to build my electronic survey; this made it possible for me to reach a nationwide sample. I am deeply grateful to my committee members: Dr. Barbara Rienzo for her inspiration, Dr. David Miller for statistical consultation and teaching, Dr. Sondra Smith for her academic excellence and her role as a mentor for my teaching experience, and Dr. Peter Sherrard for his continued supervision and coaching and his wonderful ideas that got this research started in the right direction. I thank each of them for valuable comments, revisions, and references during the course of my research.

I am indebted to the department chair, Dr. Harry Daniels, for supporting my education through a Graduate Teaching Assistantship in the department to allow me to work and to gain university teaching experience that will be valuable for future endeavors.

I would also like to acknowledge Dr. Max Parker, Ph.D., for being a mentor to me throughout my program and for being available for consultation whenever I needed him. The training that I received from Dr. Mary Howard Hamilton in her consultation class

proved helpful in my professional development as a consultant. She also provided mentorship throughout my program and was always available for consultation.

Personally, I acknowledge my parents, Rose and Roy, for their continued support; my brothers, Dominick and Daniel, for unconditional love; and especially my partner, E. J. Updyke, LMFT, for compassion, understanding, and patience through this process. Others who contributed and whom I wish to thank include Jason Burkhardt for computer consultation; Rosaria Upchurch, LMFT, for support and wisdom; Rebecca Waumett, graduate student, who helped me to prepare email lists and databases; Mike Padilla from educational psychology, who helped with methods selection and data analysis; Amy Bradshaw, fellow doctoral student, for statistics coding, data entry, and dear friendship; and Gary Sipe and the entire Stetson University CIT department for their help with the SurveyWiz program, development of the online survey development, and resolving glitches along the way.

Another mentor who is acknowledged for her contributions is Dr. Mickie Miller, who took me under her wing as a graduate assistant at the University of Florida and at the Brain Institute and helped me to develop courses. I acknowledge the Gainesville Family Institute and its two faculty members, Dr. Herb Steier and Dr. Gina Early; I am grateful for their constant consultation and coaching throughout my graduate program. Their support and mentorship have changed me personally and professionally to be a better person. Last, I thank all of my supervisees and interns from whom I have learned so much over the years at the university; it has been a pleasure to work closely with them.

TABLE OF CONTENTS

Page

LIST OF TABLES

Abstract of Dissertation Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy

THE CURRENT STATUS OF MARRIAGE AND FAMILY THERAPISTS' GRADUATE TRAINING IN THE IDENTIFICATION, ASSESSMENT, AND TREATMENT OF RELATIONSHIP VIOLENCE

By

Marie T. Bracciale

August 2004

Chair: Silvia Echevarria-Doan
Major Department: Counselor Education

The incidence of relationship violence (RV) has increased dramatically in the past decade. Clinical counselors trained in marriage and family therapy (MFT) who interact with perpetrators and victims of RV must be informed about associated personality factors, transactional dynamics of perpetrators and victims, structural and environmental influences leading to RV, and comparative effectiveness of intervention strategies. This national study focused on graduate MFT training received by clinical members of the American Association of Marriage and Family Therapists (AAMFT).

The Relationship Violence Training Survey (RVTS), designed by the researcher and measured for content validity by experts in the field, contained two subscales: (a) assessment of RV, and (b) training/treatment issues in RV. Demographic data included age, ethnicity, gender, years of therapy experience, and years of supervisory experience. The RVTS was designed to measure whether graduate MFT programs adequately prepare therapists in assessment and treatment of RV. Program success was measured by survey

responses regarding required coursework in RV, program endorsement by accreditation standards, and practitioners' self-reported self-efficacy in assessing and treating RV. Respondents were 197 clinical members of AAMFT, AAMFT approved supervisors, and faculty members in MFT training programs, obtained via nationwide random sampling (response rate of 19.7%).

Statistical analysis of responses to the RTVS indicated three factors: (a) respondents' rating of the importance of clinical competencies associated with the identification, assessment, and treatment of RV; (b) respondents' rating of their graduate training in RV; and (c) respondents' self-rating of their knowledge and skills in identification, assessment, and treatment of RV. Cronbach alphas for the three factors were .814, .967 and .812, respectively.

The study results indicated problems in the ability of responding practitioners to (a) use systematic risk assessments to recognize imminent danger and formulate appropriate interventions, (b) intervene within violent gay and lesbian relationships, and (c) obtain Restraining Order Injunctions. The need for improved quality and longer duration of graduate training in RV and more stringent training requirements by licensing boards and accreditation standards were supported. The results may be helpful to researchers, treatment providers, graduate programs, accreditation boards, third-party payers, and benefits officers.

Abstract of Dissertation Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy

THE CURRENT STATUS OF MARRIAGE AND FAMILY THERAPISTS' GRADUATE TRAINING IN THE IDENTIFICATION, ASSESSMENT, AND TREATMENT OF RELATIONSHIP VIOLENCE

By

Marie T. Bracciale

March, 2004

Chair: Silvia Echevarria-Doan
Major Department: Counselor Education

The incidence of relationship violence has increased dramatically in the past decade. This national study focused on training that clinical members of the American Association of Marriage and Family Therapists (AAMFT) received during their graduate marriage and family therapy (MFT) programs.

The Relationship Violence Training Survey was designed to measure whether these programs prepare therapists in assessment and treatment of relationship violence. Respondents were 197 clinical members of AAMFT, AAMFT approved supervisors, and faculty members in MFT training programs, obtained via nationwide random sampling. Results may be helpful to researchers, treatment providers, graduate programs, licensure boards, accreditation standards, third-party payers, and benefits officers.

CHAPTER 1
INTRODUCTION

Whether or not human beings are inherently aggressive, as some have asserted (Lorenz, 1966), it appears that they are most likely to behave aggressively in their most intimate social relationships. Almost one fourth of all murders occur between relatives, most often involving spouses killing one another (Straus, 1986). Child abuse, spouse abuse, and elder abuse have become substantial problems in their own right. Date rape and courtship violence occur with distressing frequency. Violence between homosexual couples also has been documented in the literature. No type of interpersonal relationship seems to be immune (Rosenbaum, Cohen, & Forsstrom-Cohen, 1991). In 2000, the number of females shot and killed by a husband or intimate acquaintance was nearly 4 times higher than the number murdered by male strangers (Centers for Disease Control and Prevention, 2001).

Why should one conduct a national survey of practices in assessment and treatment of relationship violence? Due to the large increase of violence in society (as the statistics will show), this survey is needed to respond to this incidence. Ethically, we need to respond as an organization to have an impact on our clients, our research, our treatment protocols, and our community/courts systems.

Very few national studies have been done on marriage and family therapist practices. None has directly surveyed practices directly relating to relationship violence. The results will be information of importance to researchers in the field, treatment

providers, graduate programs, and accreditation boards. It may also be helpful to third-party payers and benefits officers.

In 1995 Doherty and Simmons conducted the first national survey of marriage and family therapists on clinical patterns of marriage and family therapists. Their sample of 526 therapists from 15 states gave descriptive information on their training, level of experience, and professional practices, along with detailed information on recently completed cases. The findings indicated that marriage and family therapists treat a wide range of serious mental health and relational problems, that they do so in relatively short-term fashion, and that they use individual, couple, and family treatment modalities (Doherty & Simmons, 1996).

The goal of this project is to obtain detailed information about the clinical practices of clinical members of the American Association of Marriage and Family Therapists (AAMFT) throughout the United States. Specifically, the Relationship Violence Training Survey (RVTS) is designed to answer questions about the adequacy and competencies of marriage and family therapists, supervisors, and faculty members in identification, assessment, and treatment of relationship violence and to look at the current status of graduate training in relationship violence (appendix A).

The theoretical basis for this study is drawn from (a) the increase in incidence of relationship violence as indicated by statistics; (b) professional responsibility: legal, ethical, and therapeutic issues; (c) multiforms of treatment (metatheoretical, postmodernism, feminism, sociocultural, social learning); and (d) identification of training needs.

Increase in Incidence of Relationship Violence

In the United States today, violent crimes occur more frequently within families than among strangers (Gelles & Straus, 1988; Langan & Innes, 1986; Straus & Gelles, 1990). Government surveys conducted between 1973 and 1981 identified 4.1 million reports of intrafamilial victimizations (U.S. Department of Justice, 1984). In 1990 alone, of the 6,008,790 crimes of violence against persons ages 12 and older reported in a national crime victimization survey (U.S. Department of Justice, 1992), 39% were perpetrated by a member of the victim's family or by a person in a relationship with the victim. Less than half of these crimes were reported to the police. Fifty-eight percent of crimes reported involved the spouse or ex-spouse of the victim.

Although intimate partner violence (IPV) is known to occur among all social classes, research over the past 30 years has demonstrated a consistent link between low socioeconomic status (SES) and occurrence of partner violence (Gelles, 1997). In terms of clinical studies, O'Brien (1971) found that, in a sample of divorcing couples, the husband's achievement status (measured by job dissatisfaction, education, income, and occupational status) was much lower among the violent couples than among the nonviolent couples. Gayford (1975) and Roy (1977) found that husbands of battered women tended to hold unskilled occupations and have high levels of unemployment. Hotaling and Sugarman (1986), in their review of 52 case comparison studies, found that three indicators of the husband's SES (occupational status, income, and educational level) demonstrated a consistent inverse association with the occurrence of husband-to-wife violence (Cunradi, Caetano, & Schaefer, 2002).

Data from the 1992-93 National Crime Victimization Survey indicate that young women (ages 19-29) in low-income families (under $10,000) were more likely than other

women to be victims of partner violence (Bachman & Saltzman, 1995). Longitudinal research suggests that men characterized by low SES indicators (unemployment, low educational attainment) are more likely to initiate IPV than men without such characteristics (Magdol et al., 1977), and these indicators are associated with the persistence of wife assault over time (Alderondo & Sugarman, 1996). On the other hand, Quigley and Leonard (1996) found no significant differences in education between couples whose husbands desisted their marital violence after 2 years of follow-up and those who did not (Cunradi, Caetano, & Schaefer, 2002).

Professional Responsibility: Legal, Ethical, and Therapeutic Issues

The duty to warn third parties of dangers posed by a client's behavior, as Monahan (1993) noted, "is now a fact of professional life for nearly all American clinicians" (p. 242). Family therapists, when deciding whether to warn a third party of a threat resulting from a client's behavior, must consider legal, ethical, and therapeutic issues. On the one hand, courts in most states have ruled that therapists have a legal duty to warn (or avert danger to) third parties to whom clients pose a risk. On the other hand, certain sorts of client confidences are protected by law. Thus, therapists must determine whether they have a legal duty to warn third parties of the danger posed by their client's behavior and, if not, whether the client's information is legally protected (thus prohibiting the therapist from disclosing the information). Ethical and therapeutic issues arise about client information that state law does not expressly require or forbid therapists to disclose. In such cases, therapists and clients are generally free to negotiate a mutually agreeable disclosure policy.

All three factors (legal, ethical, and therapeutic) play a role in formulating the written disclosure policy statement that each therapist should negotiate with prospective

clients. Some states regulate disclosure statements. In any case, therapists' disclosure policies must conform to all applicable laws.

The landmark case establishing that therapists, in certain cases, have a legal duty to warn potential victims of their clients' behavior is *Tarasoff v. Regents of University of California* (1976). The details of the case are well known. In the course of therapy, Prosenjit Poddar threatened to kill Tatiana Tarasoff, a fellow student in his square dancing class. (Although Tarasoff was not mentioned by name, the therapist was well aware of the identity of the potential victim.) Poddar was held for observation and then released. No one notified Tarasoff of the threat that Poddar had made against her. Two months later, Poddar murdered Tarasoff, and the Tarasoff family filed suit. The court held that "when a therapist determines or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger" (p. 346).

A disclosure statement is a written document detailing the policy, negotiated between therapist and client, concerning therapist disclosure of client information. (Frequently, the document expresses the standard policy of the therapist and is signed by the client.) It should inform the client of the therapist's legal responsibilities and indicate how the therapist will use discretion within the limits of the law (Schlossberger & Hecker, 1996).

The legal evolution of the "battered women's defense," as it came to be known, was built on the "rape defense" successfully argued by lawyer Susan Jordan in the second trial of Inez Garcia and the successful appeal filed by Jordan, Nancy Stearns, and Liz

Schneider for Yvonne Wanrow, the Spokane woman hobbling on crutches who killed a man for molesting her son. Armed with new, and newsworthy, feminist concepts—"battered women's syndrome," "unequal combat," and "imminent danger"—their defense strategies helped to focus a spotlight on domestic violence. After nearly a decade of feminist agitation in concert with legislative initiatives pioneered by Representative Lindy Boggs and Senator Barbara Mikulski, Congress passed the Family Violence Prevention and Services Act in 1984. Today, approximately 1,800 battered women's shelters, hot lines, and advocacy programs around the country are funded by the federal program (Brownmiller, 1999).

Ethical Standards of the Commission on the Accreditation of Marriage and Family Therapy Education (COAMFTE)

The Commission on Accreditation for Marriage and Family Therapy Education was established by the AAMFT Board of Directors in 1974. In 1978, the Commission gained official recognition by the U.S. Department of Education as the accrediting agency for the graduate degree and post-degree training programs in marriage and family therapy. These training programs are located throughout the United States and Canada. In 1978, in recognition of its increased level of activities and responsibilities, the Commission was restructured and renamed the COAMFTE.

The Commission on Recognition of Post-secondary Accreditation (CORPA) officially granted recognition to the COAMFTE in 1994. CORPA is a nongovernmental organization that works to foster and facilitate the role of accrediting bodies in promoting and ensuring the quality and diversity of American postsecondary education.

COAMFTE serves under a broad mandate from the AAMFT Board of Directors to set standards for and accredit master's, doctoral, and post-degree clinical training programs in marriage and family therapy (COAMFTE, 1994).

Specific standards developed by the COAMFTE (appendix B) outlining the importance of this study include the following:

320: Area II: Clinical Knowledge

320.02 Area II content will address contemporary issues, which include but are not limited to gender, violence, addictions, and abuse, in the treatment of individuals, couples, and families from a relational/systemic perspective.

340.04 Area IV will address the AAMFT Code of Ethics [appendix C], confidentiality issues, the legal responsibilities and liabilities of clinical practice and research, family law, record keeping, reimbursement, and the business aspects of practice. Area IV content will inform students about the interface between therapist responsibility and the professional, social, and political context of treatment.

Accreditation Bodies

COAMFTE Preamble to the Standards on Accreditation, Version 10.2

Accreditation is a voluntary process on the part of the program whose major purpose is to ensure quality in a marriage and family therapy program. All accredited programs are expected to meet or exceed all standards of accreditation throughout their period of accreditation. The integrity of an institution and the program is fundamental and critical to the process of accreditation. Accreditation standards are usually regarded as minimal requirements for quality training. All accredited programs are free to include other requirements, which they deem necessary and contribute to the overall quality of the program. Programs must continually evaluate their programs in relation to their institution's mission and their own program mission, goals and educational objectives. Accreditation standards, like other aspects of accreditation, are part of a slowly evolving, continuous process. In the long view, there are continuing conversations among accreditors, training programs, trainees, trained professionals, employers, and consumers from which the standards and other aspects of accreditation evolve.

The objective of these standards is to assure, as much as possible that individuals trained in accredited programs are competently trained to become marriage and family therapists at the entry and doctoral levels. The standards are designed to be unique to the practice and supervision of marriage and family therapy. Some standards apply to training programs in general, including elements such as

> organizational stability, faculty accessibility, appropriate student selection processes, and fairness to students and employees. Some standards apply to all psychotherapy training, including elements such as adequate numbers of client contact hours and supervision hours.
>
> Graduates from COAMFTE accredited marriage and family therapy programs are trained to be clinical mental health practitioners. COAMFTE adopts the Standard Occupational Classification of the Bureau of Labor and Statistics which states that Mats are qualified to "[d]diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. [They] Apply psychotherapeutic and family systems theories and techniques in the delivery of professional services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders." All persons properly trained in marriage and family therapy are to be competent in working with individuals. (American Association for Marriage and Family Therapy, 2003)

Marriage and family therapists are bound ethically by the standards of accreditation and clinical ethical guidelines to understand the importance of assessing for abuse and violence with each case. In some cases, the reasons that abuse and violence are present may be difficult to detect.

Scope of the Problem

Current researchers who report on the treatment of relationship violence have only recently written that this type of treatment is evolving into a specialized field. Although for many years there have been specialized treatment programs available in a few states, it is only recently that the need has been recognized to develop and fund specialized treatment programs in every state. This recognition has been spurred on by two factors: (a) increasing and widespread acknowledgement of the extent of the problem, and (b) increasing acceptance that traditional forms of therapy are not effective with the relationship violence population (Crawford, 1981).

Two decades of empirical research on child abuse, wife beating, and domestic violence are conclusive on one point: The causes of violence are multidimensional (Gil,

1971; Straus, Gelles, & Steinmetz, 1980). There is no one cause of this violence—not poverty, not stress, not mental illness or psychopathology, not being raised in a violent home, and not alcohol and/or drugs (Gelles & Maynard, 1987).

It is apparent that the treatment for a multidimensional problem would include varied approaches, depending on the context. Straus's (1973) general systems model of violence between family members was one of the first theoretical applications of a systems perspective to family violence. Another presentation of a research systems model is Giles-Sims's (1985) examination of wife battering. Giles-Sims's systems models looked at the factors influencing a battered woman's decision to stay, flee, and/or return to violent relationships.

The Extent of the Problem

Domestic violence is one of the most common crimes. Many of us know someone in our close family or among our friends to whom it has happened, or we have experienced it ourselves, but we tend to think that we are different or alone, not realizing perhaps just how widespread and enduring domestic abuse is. Domestic violence occurs in almost all cultures and countries, across all known divisions of wealth, race, caste, and social class. There may never have been a time when it did not exist; it certainly stretches back deep into history. Centuries, indeed millennia, are filled with millions of assaults, attacks, rapes, violations, psychological abuses, maimings, killings of women in their homes by men (Hague & Malos, 1998).

Although it is true that approximately 6 million women in the United States are beaten in their homes each year, there is more to the domestic violence picture. For example, 70% of male partners (batterers) also abuse children in the home. More tragic, boys often attempt to protect their mothers from battering and are themselves injured or

killed. Incredibly, over 60% of males ages 15 to 20 who were incarcerated for homicide had killed their mother's batterer (Summers & Hoffman, 2002).

Domestic violence is not a new phenomenon. It has been a common occurrence throughout recorded history. In many societies, women were traditionally considered the property of the man; his duty was to discipline her and the children (and slaves) with thorough beatings. The only concerns about this related to the thickness of the stick that the law allowed for the beatings. Although there were some earlier unenforced laws against spousal abuse, it was only as recently as the 1970s in the United States that the justice system began to view the problem seriously and consider domestic violence as a crime. Up until that time, social services for victims of domestic violence were almost nonexistent.

There are many contributing factors to domestic violence, usually associated with differing views of what the problem is based on. Some of these views are learned behavior, gender socialization, patriarchy or power and privilege, and risk factors, including criminal or psychological profiles. Even countries view the nature of the problem differently. For example, some of the risk factors for domestic violence in England and Wales are gender inequality, poverty, social exclusion, having a criminal background, and having experienced abuse as a child. The families are classified as patriarchal (male dominated), and women have a subordinate status. This also seems to be the case in Italy, where the view is held that religion keeps domestic violence as an isolated and personal problem rather than a serious social ill. Both the Catholic church and the state view domestic violence as a personal and private matter. Battered women are encouraged to return home to their abusing partners. In their zeal to preserve the

family, domestic violence has often been overlooked and even considered "normal." In Australia, most citizens see domestic violence as rooted in the aggressive nature of men. Yet the indigenous population sees it as learned behavior. In Jamaica, the problem is regarded as stemming from a lack of education, abject poverty, drug abuse, and the mythology surrounding the traditional role of the male. In Russia, Germany, and Slovenia, major political change is identified as another contributing factor (Summers & Hoffman, 2002).

Overall, domestic violence presents a profoundly disturbing and distressing picture. Some people choose to turn away from that picture. Partner abuse is an epidemic with potentially dire consequences for individuals, families, and society. Family therapists must be competent to assess for and intervene in abuse situations (Haddock, 2002).

Multiforms of Treatment (Metatheoretical, Postmodernism, Feminism, Sociocultural, and Social Learning)

Various theoretical and treatment approaches are being used within the relationship violence field. Four of these approaches are reviewed in this section.

Metatheoretical Approach

Metatheoretical, as a general term, refers to the philosophical (e.g., epistemic, ontological, metaphysical) assumptions that influence or form the basic structure of various disciplines in science and the social sciences (Hoshmand, 1996). When working with batterers, the most therapeutic interventions in cases of relationship violence are still based on behavioral approaches (Bagarozzi, 1983; Taylor & Gunn, 1984). Cook and Franz-Cook (1984) presented a systematic treatment approach to wife battering. Margolin (1979) and Taylor and Gunn proposed conjoint therapy for spouse abuse cases. The radical feminist perspective and the systemic view of family violence are not

mutually exclusive, and Cook and Franz-Cook stated that treatment based on both views is necessary and important.

Archer (2000), in a meta-analysis, compared samples selected for male violence (from battered women's shelters) with community samples to assess whether the couple violence looked different across these populations. Very high levels of male aggression were reported in shelter samples, whereas in community samples women were slightly more physically aggressive. Archer also examined studies of couples undergoing treatment for marital problems and found that men were slightly more likely than women to be physically aggressive. However, in contrast to shelter samples, the level of male aggression was much lower. This suggests that couples receiving counseling, even for problems specifically related to male violence, do not have nearly the same kind of imbalance in physical aggression as might be found in couples in which the woman has sought shelter from abuse (Greene & Bogo, 2002). This study will describe current empirical research to support a conceptual framework for helping marriage and family therapists to assess and treat relationship violence. Depending on the context, flexibility in searching for approaches when working with the needs of couples may be indicated. A broader lens that takes into account the various faces of intimate violence may expand alternatives for assessing and treating these couples (Greene & Bogo, 2002).

Postmodernism

Postmodern perspectives have had considerable impact on the field of couple therapy in the 1990s. Focused on self-organizing and proactive features of human knowing, they emphasize that reality is constructed, reflecting language, culture, and social context (Anderson, 1997; Neimeyer, 1993). Meaning and knowledge are seen as being created through social communication with others. The most radical forms of

constructionism see every case as unique and suggest that no single version of reality or problem formulation is better than another. Problems are viewed as "interpretations" that can be "dis-solved" in language (Anderson).

Specific techniques have been developed in solution-focused and narrative therapies to help clients to "deconstruct" the problematic aspects of their relationship and allow new possibilities to emerge. However, there are many ways to help clients to create new meanings and many ways to access and work with aspects of experience that have gone "unstoried." More generally, this perspective may be viewed as an "attitude" or philosophical stance for therapy rather than as a model for intervention or a set of techniques.

From a respectful, collaborative stance, therapists regard clients as experts on their own reality and discover with clients how they construct that reality. Therapists show sensitivity to each individual and enlarge the frame to include larger contextual issues, such as gender, class, and culture. Therapists also focus more on a couple's strengths and competencies, striving to honor and validate clients' wisdom and strengths in dealing with difficult realities. Social-constructionist ideas can also be integrated with more traditional research if certain guidelines are followed (Myers Avis, 1996); for example, if researchers recognize and reveal their own values and beliefs with the research context.

Sociocultural Theory

The search for the causes of domestic aggression has focused largely on sociocultural and psychological factors. It has been a short search, the primary strategy of which has been to identify characteristics of participants that distinguish them from their nonaggressive counterparts. It has been an atheoretical search in which theory is occasionally invoked, post hoc, to explain one or another research finding. Social

learning theory, for example, is used as an explanation for the intergenerational transmission of aggression, and female masochism is sometimes employed to account for the battered woman's reluctance to leave an abusive mate (Rosenbaum & O'Leary, 1981).

Sex-role socialization, in general, tends to support the notion that the success or failure of intimate relationships is the woman's responsibility, and this may lead some women to make great efforts to stay in intimate relationships, even after episodes of abuse, to show their commitment to their partner and to weathering the "difficult times" together (Dutton & Painter, 1981; Strube, 1988). In addition, when an abusive event occurs, the woman may presume that it will not recur, and so will "try to make the relationship work under the belief that, if she tries hard enough, her efforts will succeed" (Strube, p. 240).

Sociological and sociocultural theory assumes that social structures affect people and their behavior. The major social structural influences on family violence are age, gender, position in the socioeconomic structure, and race and ethnicity (Gelles, 1983).

Social Learning Theory

According to Bandura's (1973, 1977) social learning analysis of aggression, witnessing interparental violence may predispose some young males to abusive behaviors in their adult intimate relationships with women. Social learning theory maintains that violence (in the form of a learned response) is transmitted from the family of origin to the adult intimate dyad through the vicarious reinforcement of interpersonal violence as a method of conflict resolution and a means to the maintenance of power and control in intimate relationships.

In addition to external reward/punishment contingencies, Bandura (1973) proposed that the following self-regulatory mechanisms modulate self-recrimination processes by "neutralizing" aggressive behaviors: (a) justification of the behavior on the basis of some higher authority (e.g., scripture); (b) comparison of the behavior with more serious violence; (c) projection of responsibility for the behavior onto drugs, alcohol, work stressors, or the provocation of the victim; (d) normalization of the behaviors as a common and socially acceptable occurrence; (e) depersonalization of the victim through the use of disparaging labels; and (f) minimization of the consequences of the behavior. One or more of these neutralizing tactics have been observed among batterers in treatment (Carden, 1994).

Treatment for Battered Women

Varieties of counseling approaches have been proposed for battered women in recent years, including grieving, existential, and shame therapy (Turner & Shapiro, 1986). Some of these approaches are reviewed in this section.

Empowerment and safety-based interventions have been found useful. In her text *Counseling Female Offenders: A Strength-Restorative Approach*, Katherine Van Wormer (2001) established a link between the crimes of female offenders and environmental factors such as substance abuse and sexual abuse. Combining strategies from the fields of criminal justice and social work, she showed how to empower female offenders and how to rehabilitate them to society by building on their personal strengths. From her unique "strengths-restorative" approach, the author presented strategies for anger management, substance abuse treatment, and domestic violence counseling.

In 2000, the University of Northern Iowa applied for and received a federal grant to combat gender-based violence in a comprehensive manner. The planning and

implementation of the grant used an interdisciplinary approach, linking pre-existing law enforcement, prevention programs, and victim services while adding a variety of new tools and efforts. Below are some of the new and expanded programs offered as part of the Violence Against Women grant. Some of the programs that they have developed are RAD—Rape Aggression Defense Class and a Blue Light program, with five blue light safety phones spread throughout the campus. These are some examples of safety prevention programs that are effective and work well to decrease violence on campuses (University of Northern Iowa, 2003).

Fundamental to the counseling efforts should be a design to move the battered woman from status as a "victim" to that of a "survivor" (Rieker & Carmen, 1986). It is this shift in self-perception that is most associated with safety and recovery (Gondolf & Fisher, 1988).

The Duluth Model (Minnesota Program Development, 2003) contacts partners of offending men and offers advocacy, community resources, and a women's group. The model uses a curriculum called In Our Best Interest: A Process for Personal and Social Change for their battered women's group. Women who have been arrested for using violence are also ordered to attend nonviolence classes.

According to several victimization studies, battered women tend to move through several phases in response to abuse (Ferraro & Johnson, 1983; Mills, 1985). These phases are distinguished by an attributional shift on the woman's part. In essence, she begins to perceive that the battering was not "all her fault" but was largely due to her husband's behavior. It is not up to her to change the batterer; in fact, it is not likely that

he will change. Instead, she is capable of taking care of herself, with the support and assistance from others that she deserves (Gondolf & Fisher, 1991).

Therefore, the objective in counseling might be to reinforce and encourage this realization. Many shelters subscribe to an "empowerment" mode of counseling to achieve this end. The feminist approach is directed toward helping the woman to realize her options and choices and to begin to make decisions that assure her worth, integrity, and determination (Bograd, 1988). One study of formerly battered women rated this sort of counseling to be the most effective in stopping violence (Bowker, L., 1983).

Some clinicians (e.g., Almeida & Durkin, 1999) who are sensitive to issues of power, abuse, and trauma have recommended the use of gender-specific support groups for the victim as the most appropriate treatment strategy. It can be noted that a combination of individual and group treatment is often desirable.

Some theorists have argued against the use of couples therapy in situations of abuse (Avis, 1992; Bograd, 1992; Dutton; 1992). However, feminist-identified family therapists have begun to experiment cautiously with the use of couples treatment in situations of abuse (Goldner, Penn, Sheinberg, & Walker, 1990; Jenkins, 1990; Jory & Anderson, 2000). Some therapists are using proposed criteria to determine situations in which couples therapy may be appropriate. These indicators, listed by Bograd and Mederos (1999), rule out the appropriate use of couples therapy. Since the issues of partner abuse situations are complex, therapists should resist formulaic approaches to treatment planning. Relevant variables should be carefully considered in making treatment decisions, such as the power differential between the partners, the nature and extent of the abuse, lethality indicators, the effects of the abuse on the victim, the ability

of the victim to stay safe, the resources of the victim, the responsibility taken by the perpetrator, and the commitment to change demonstrated by the perpetrator (Haddock, 2002).

Treatment for the Batterer

The treatment of batterers has similarly seen a proliferation of approaches and, with it, increased debate. The leading programs are characterized by group process that prompts men to take responsibility for their abuse, to exercise alternatives to the violence, and to restructure their sex-role perceptions (Gondolf, 1987b). However, there is a questionable trend toward short-term anger control treatment that unwittingly reinforces the batterer's penchant for control (Gondolf & Russell, 1986).

The research on cessation suggests that batterers who reform their behavior pass through a series of developmental stages (Fagan, 1987; Gondolf, 1987a). The change process begins with "realization." The egocentric batterer acknowledges the consequences of his abuse and that it may be in his own self-interest to contain the anger that led to the abuse. Gradually, the batterer becomes more "other oriented" and begins to make "behavioral changes" to improve relationships, or at least to avoid totally destroying them. Some men eventually begin to think more in terms of values and principles and integrate these into a change of self-concept. Consequently, a number of leading batterer programs employ a phased approach that moves batterers from didactic sessions of accountability and consequence to social support groups with a focus on service (Gondolf, 1985).

When treating batterers, marriage and family therapists should be aware of the heterogeneity among batterers across several dimensions, including the severity of the violence and the psychopathology and physiological responses of the batterer

(Holtzworth-Munroe, Smutzler, Bates, & Sandin, 1996; Jacobson & Gottman, 1998). Understanding the differences between two types of batterers—Type 1 ("cobras") and Type 2 ("pit bulls")—can also be useful (Gottman et al., 1995; Jacobson & Gottman). These typologies are described in the literature review section of this dissertation.

According to Haddock (2000), novice therapists should be advised against treating most perpetrators of abuse; indeed, for court-ordered batterers, most states mandate certain kinds of treatment by certified professionals. Therapists should be familiar with local agencies that serve batterers and the methods for making referrals to local batterer-specific treatment programs.

Duluth Model

In 1981 nine city, county, and private agencies in Duluth, Minnesota, adopted policies and procedures that coordinated their intervention in domestic assault cases. These measures focused on protecting victims from continued acts of violence by combining legal sanctions, nonviolence classes, and, when necessary, incarceration to end the violence. Consistently applied, their message to offenders is clear: "Your use of violence is unacceptable."

The Domestic Abuse Intervention Project (DAIP) was the coordinating agency for this effort. An additional component of the DAIP was the nonviolence program, which consisted of classes for offenders who were court-ordered to the programs. The programs used the curriculum "Power and Control: Tactics of Men Who Batter," a 24-week educational curriculum (Pence & Paymar, 1993).

Batterer intervention programs, which seek to educate or rehabilitate known perpetrators of IPV to be nonviolent, have proliferated since the 1980s under the auspices of both the criminal justice system and the mental health system. Three theoretical

approaches to the conduct of these programs have been consistently documented (Healey, Smith, & O'Sullivan, 1997): society and culture, the family, and the individual. These theories influence the content and delivery of interventions.

Society and Culture

Feminist theorists attribute battering to social and cultural norms and values that endorse or tolerate the use of violence by men against their women partners. The feminist model of intervention educates men concerning the impact of these social norms and values and attempts to resocialize men through education, emphasizing nonviolence and equality in relationships.

It has been well documented by feminist researchers that gender is a central organizing principle for both individuals and couple relationships and therefore must be an integral feature in family therapy (Goldner, 1985; Hare-Mustin, 1986). More research, analysis, and understanding are needed regarding how intersecting factors such as gender, class, race, and ethnicity operate in cases of couple violence.

We must acknowledge the limits of generalizations that can be made on the basis of populations included in research to date. Most couple therapy clients are White and middle class. The considerable influence of cultural diversity and changing gender roles is, as yet, largely unexamined (Johnson & Lebow, 2000). The adaptation of couple and family therapy to consider the impact of culture will be a vital concern of future research in the field.

The Family

Family-based theories of IPV focus on the structure and social isolation of families. The family systems model of intervention focuses on communication skills, with the goal of family preservation, and may use couples counseling/conjoint therapy. Wife battering,

like other forms of family violence, raises a variety of family issues. But, unlike child and elder abuse, it threatens the very foundation of the family structure—the marriage (or partnership). Therefore, the most crucial family issue is whether the family is to continue. Given the tendency of wife battering to escalate and denial of the problem to persist, most practitioners in the field have, in the past, strongly recommend separating the batterer from the battered women and children (Gondolf & Fisher, 1991).

The Individual

Psychological theories attribute perpetration of IPV to personality disorders, the batterer's social environment during childhood, or biological predispositions. Psychotherapeutic interventions target individual problems and/or build cognitive skills to help the batterer to control violent behaviors.

Summary

Currently, there is little evidence to suggest the effectiveness of one approach over another or of the differential effectiveness of different programs with different "types" of batterers, although one study has suggested that process-psychodynamic groups may function better for men with dependent personalities and cognitive-behavioral groups may be more effective for those with antisocial traits (Saunders, 1996).

The most widely evaluated intervention model for men who batter is that of group interventions using cognitive-behavioral techniques, often in combination with feminist content. One review of these studies reported that rates of successful outcomes (i.e., reduced or no reassault) from these programs varied from 53% to 85% (Tollman & Bennett, 1990). However, other reviews have pointed out those methodological problems in the studies limit conclusions about the effectiveness of such programs.

Graduate Training in Relationship Violence: Identification of Training Needs

The importance of intervening in cases of so-called "minor" spousal violence is underscored by the assumption by many researchers that minor violence, if left untreated, can escalate into severe or life-threatening violence (Rosenberg, 1985). In most graduate programs, this area of assessment is poorly presented, unless graduate students specifically discuss relationship violence during intake. Research suggests that, unlike graduate students, emergency personnel are well trained in this area of assessment, since these personnel are primarily working the "front lines" with respect to relationship violence victims. These personnel have incorporated violence assessments into their intake procedures.

According to Wolf-Smith & LaRossa (1992), professional counselors, therapists, and social workers have an obligation to help victims to gain insight into their abuse. They also have an obligation to be nonjudgmental of whatever decision a woman makes about her abusive relationship. Professionals provide varied services to victims and their families to help heal the effects of violent relationships. Treatment providers may recommend many different approaches, including individual, group, and/or family therapy. However, the specific treatment approaches that are currently being taught in graduate school training for counselors are unknown. Furthermore, it is unknown whether the treatment recommended varies depending on the context of the case. Are professionals being trained to treat the victim? the batterer? the couple? the individual? the family? Is there coursework from a relationship-violence context or through a relational violence lens? This information would allow the professional counselor to gain knowledge in treating clients who present with issues of relationship violence.

"Victims of male battering face difficult choices—choices about what to say to their abusers, choices about whether to stay. Respecting the choices that women make is an integral part of the counseling/therapeutic process" (Wolf-Smith & LaRossa, 1992, p. 324).

Understanding the tendency to reduce the inherent complexity of partner abuse cases in response to concerns about potential lethality, therapists would benefit by learning to conceptualize each case within its own unique and multifaceted context (Dutton, 1992; Goldner, 1999), while attending to the intersections of gender, race, class, religion, and sexual orientation (Bograd, 1999).

Goldner's (1992, 1999) "both/and" stance can be introduced as a way to manage these complexities.

> There is an enormous pressure to "get it right" immediately and, as a result, the impulse is to lapses into extremes: to side with one partner against the other, to refuse to ever take sides at all, to exaggerate or minimize danger, to insist on a particular paradigm and argue against all others—in other words, to polarize everything. (Goldner, 1992, p. 56)

Part of the difficulty for faculty and marriage and family supervisors in training students effectively has been that the domestic violence literature includes disparate and controversial findings. On the one hand, studies of community samples find generally low levels of violence perpetrated by both males and females. On the other hand, studies of clinical samples drawn from courts, hospitals, and shelters find severe violence, mainly perpetrated by men (Archer, 2000; Johnson, 1995). For instance, feminist researchers have studied primarily clinical samples and have concluded that intimate violence is the result of patriarchy and, thus, is primarily perpetrated by men as a means to maintain power and control (Dobash & Dobash, 1979; Pagelow, 1984). Family conflict researchers have studied mainly representative community samples and have

concluded that intimate violence between partners results from individual, relational, and societal variables that tend to be more gender neutral (Berkowitz, 1993; Straus & Smith, 1990). These two different perspectives have led to a longstanding debate about the veracity of each position, which impacts training in terms of approaches taken to address the identified problem.

The majority of studies on couple violence have limitations, notably largely using samples involving only severely violent men. Conclusions and conceptualizations about violence and appropriate clinical interventions have been generalized from these samples to all couples in which there is aggression (Johnson & Ferraro, 2000). Comparably little research has involved couples voluntarily seeking conjoint treatment for intimate violence (Brown & O'Leary, 1997). Despite growing evidence of difference between these populations, distinctions have yet to be included in assessment (Greene & Bogo, 2002).

Assessment of Violence in Treatment

For those professionals using traditional assessment methods, rather than assessments geared toward gleaning information about relationship violence, clients may be allowed to "maintain the silence," since appropriate questions are not asked initially. Without vital skills in assessing relationship violence specifically, counselors are more likely colluding with the system to maintain the violence and thus may be putting their clients at risk. It is unclear why the majority of counselors are not trained in this important area of assessment.

Previous research establishes a precedent for needed improvements in the education and training of psychotherapists. For example, Hansen, Harway, and Cervantes (1991) surveyed the national membership of the AAMFT. Therapists participating in the survey

were asked to read two vignettes with proven therapeutic interventions for domestic violence cases portraying female victims and domestic violence. The results indicated that most of the counselors did not attend to the seriousness of the violence and many did not attend to it at all. Indeed, one of the vignettes was based on an actual case study in which a family member had been killed. In this survey of 362 members of the AAMFT, respondents were asked to conceptualize the case and to describe how they would intervene. Forty-one percent of those surveyed indicated no recognition of domestic violence.

The use of various written assessments for detecting abuse and violence may prove beneficial. One such instrument is the HCR-20: Assessing Risk for Violence (Version 2) by Webster, Douglas, Eaves, and Hart (1997). Another assessment tool is the Clinical Guidelines on Routine Screening published by the Family Violence Prevention Fund and available at no cost from their Web site. This includes screening questions, history intake form, abuse assessment screen, domestic violence screening/documentation form, assessment of patient safety, referrals, reporting procedures, and photographs that might be taken (Family Violence Prevention Fund, 2003)

To underscore the importance of assuming abuse with each case until ruled out, Bograd and Mederos (1999) developed a comprehensive protocol for screening for abuse. Therapists should also be informed of other written instruments, including multimodal assessments of partner abuse (Alderondo, 1998; Alderondo & Strauss, 1994; Gottman, 1999).

In her 2002 text *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* Najavits discussed safety plans as well as many other resources, including

individual and group therapy guidelines. *Seeking Safety* also provides clinicians with a session format, including a check-in and check-out procedure that helps the client to commit to safe coping strategies.

Dunford (2000), along with other researchers (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Saunders, 1996; Waltz, Babcock, Jacobson, & Gottman, 2000), has suggested that treating physically aggressive men as one homogenous group, rather than tailoring interventions according to the different motivations and needs of physically aggressive men, could be responsible for the ineffectiveness of treatment. Dunford urged therapists to give "full and preferential attention" to the possibility that one-size-fits-all approaches to treatment may not meet the needs of these couples (p. 475). Examining the effectiveness of distinguishing between couples in various types of violent relationships and tailoring treatment interventions accordingly constitutes a promising area for future clinical exploration and empirical research (Greene & Bogo, 2002)

In the cases of common couple violence, intervention should maintain a dual and simultaneous focus on both anger management and relationship building. Gottman's (1999) research has also highlighted the importance of addressing issues beyond conflict, such as strengthening the marital bond.

Statement of the Problem

Partner abuse is an epidemic with potentially dire consequences for individuals, families, and society. As part of responding to this epidemic, researchers and clinicians suggest that therapists should develop competence in the areas of assessing and treating violence.

Intrafamilial violence has been documented in relationships of every race, religion, social class, and educational level (Straus & Gelles, 1986; Straus et al., 1980; U.S. Department of Justice, 1984, 1992). In response, theorists and practitioners have created specialized treatment methods and programs for recovery from relationship violence (Bagarozzi, 1983; Cook & Franz-Cook, 1984; Dobash & Dobash, 1979; Giles-Sims, 1981; Margolin, 1979; Straus, 1973; Taylor, & Gunn, 1984; Walker, 1979). However, battered victims often enter counseling with a marriage and family therapist without having knowledge about what type of treatment may be recommended.

Need for the Study

Data on the prevalence and seriousness of intimate partner violence vary, but they unequivocally establish partner abuse as a widespread and serious problem among heterosexual, gay, and lesbian couples (Bograd & Mederos, 1999; Carillo & Tello, 1998; Renzetti, 1997). Haddock (2002) suggested that it is imperative that family therapists possess the knowledge and skills to manage partner abuse cases effectively.

The most significant theories on treatment approaches are discussed and highlighted in this dissertation. The results of this study will have broad implications for curriculum development on the graduate level of counseling programs and graduate institutes, mental health policy and codes of ethics, social policy, and, most important, counselor efficacy in treatment of relationship violence.

If specific treatments are recommended more often because they are believed to produce positive outcomes, clinicians may be able to utilize these available interventions. Since family violence is multifaceted and multidimensional, this research may help clinicians to determine alternative treatment modalities that will prove to be successful when working with a relationship violence population.

Clearly, this information will help graduate programs to provide better and more informed, theoretically based training on the topic of relationship violence, which in turn will produce clinicians who can effectively assess risk factors for relationship violence, effectively treatment plan, create safety plans with clients, and provide valuable services to clients with problems in the area of relationship violence.

Data will be collected to answer the following questions:

1. *How do MFTs rate themselves on their knowledge in the identification, assessment, and treatment of relationship violence?*

2. *How do MFTs rate their graduate training in the identification, assessment, and treatment of relationship violence?*

3. *How do MFTs rate the importance of specified competencies and skills in the identification, assessment, and treatment of relationship violence?*

Future credentialing boards may have to expand requirements regarding training hours required in domestic violence training. By surveying professionals in marriage and family therapy, this study will provide information that may assist credentialing boards, graduate and institute training programs, and third party payers for this specific client group.

Implications of this study are not limited to graduate training programs and counseling professionals. Since this treatment issue is embedded in the context of legal, educational, medical, emergency, social, and family services, all are affected by advances in prevention and treatment programs for relationship violence.

The results of this study and its external validity will help to inform theoretical constructs in the area, as well as the current status of graduate training in relationship violence. Future research may focus on specific methodology and identification of which techniques are most often recommended in these cases.

As a result of this research, graduate schools, program developers, and managed care companies may want to create assessments that include questions addressing relationship violence to better serve their client base. These providers may find it more cost effective to screen thoroughly clients who may be in current danger for violence. Mental health professionals across disciplines may be able to use the results of this study to facilitate the prevention and treatment of relationship violence.

Purpose of the Study

The specific type of method of inquiry for this study is a Web-based survey developed by the researcher to gain information on factors related to the current status of graduate-level preparation on relationship violence within four main subtopics regarding relationship violence: identification, assessment, treatment, and training.

The primary purpose of this study is to determine the factors most frequently reported by MFTs to be related to the identification, assessment and treatment of violence via (a) a self-rating scale of their knowledge in the identification, assessment, and treatment of relationship violence, (b) a self-rating scale of their graduate training in the identification, assessment, and treatment of relationship violence and (c) their rating of the importance of competencies and skills in the identification, assessment, and treatment of relationship violence. The populations to be sampled are licensed marriage and family therapists, approved marriage and family therapist supervisors, and marriage and family therapy faculty.

The results of this survey would be helpful to the field of marriage and family therapy, as it will help to inform researchers regarding the current status of theoretical constructs currently being used in the field. The results of this survey would also be helpful in looking at clinical patterns that may be generalizable to the larger population of

marriage and family therapists, accreditation boards, and marriage and family therapist faculty and training programs.

The variables in this study are (a) the quality of graduate training in the identification, assessment, and treatment of relationship violence as reported by MFTs, and (b) competencies in the identification, assessment, and treatment of relationship violence as reported by MFTs. Additional variables are (a) the MFTs' self-rating of their knowledge in the identification, assessment, and treatment of relationship violence; (b) their ratings of the adequacy of their graduate training in relationship violence; and (c) their ratings of the importance of specified competencies and skills in the identification, assessment, and treating of relationships violence. Specific competencies and skills to be rated by the respondents include assessing for relationship violence, assessing imminent danger, performing assessments quickly, understanding batterers' typologies, identifying clients' strengths, and recognizing the signs and symptoms of relationship violence, their ability to adhere to ethical standards, their use of multicultural mode, their ability to include identification of risk factors in their assessments of clients, and their ability to recommend risk assessment manuals. Intervening or extraneous variables are demographics items such as gender, age, marital status, sexual orientation, race, discipline, years of experience, and accreditation.

The study will examine the following question: *What factors are most frequently reported by MFTs to be related to the identification, assessment, and treatment of relationship violence?*

Rationale for the Study

Given the magnitude of the problem of intrafamilial violence, it is reasonable to assume that clinical counselors in hospitals, colleges, corporations, agencies, and private

settings already interact on a regular basis with perpetrators and victims. This especially includes those working in the field of alcohol and other drug addictions. To treat relationship violence effectively, it is essential that these practitioners be informed about personality factors associated with spouse abusers; transactional dynamics of perpetrators and victims; and the structure and comparative effectiveness of existing intervention strategies. Counselors and researchers, as experts in psychosocial development, personality dynamics, and change processes, have much to contribute in the way of theoretically and empirically derived answers to the questions, "Why does he do it?" "What will stop him?" and "Why does she stay?" (Carden, 1994).

Although some models derived from certain perspectives (systemic or feminist) seem to "fit" better with certain types of violence, there is a growing recognition in the family therapy field of the need to integrate various theoretical perspectives and practice models for effective practice. Johnson and Lebow (2000) saw the trend toward integration as a "sign of a maturing field that general principles and interventions become delineated and applied in varying formats and context" (p. 32).

Lebow (1997) believed that integrative approaches have the potential to offer greater flexibility, an increased repertoire of interventions, higher treatment efficacy, and greater acceptability among clients. The last of these is particularly important in domestic violence cases, given that many clinicians have noted that women and men often want to be seen together (Goldner, 1999; Lipchick & Kubicki, 1996; Shamai, 1996). Shamai noted how the categorical dismissal of systemic principles in the treatment of domestic violence, may be akin to "throwing the baby out with the bath water" (p.

202) and serves to detract from efforts to develop a more effective, broader range of interventions.

Goldner and her colleagues at the Ackerman Institute (Goldner, 1998, 1999; Goldner et al., 1990) spent 10 years developing an integrative treatment model for intimate violence in which systemic and feminist perspectives inform and enrich one another. They have articulated how each of these perspectives in isolation from the other serves as an insufficient explanatory framework, and they highlight the need to move from an either/or orientation to a both/and position. Over the years, a complex and sophisticated "multisystemic" approach to treatment, consisting of several different approaches—feminist, systemic, psychodynamic, narrative, neurobiological, and behavioral—has been integrated under the guiding principle that one level of description or explanation does not have to exclude another (Greenspun, 2000).

This research and its results will advance the existing knowledge in the relationship violence field as it is part of a programmatic research effort. That is, when the results of the study are considered in relation to other concurrent and/or sequential studies, there may be theoretical and/or practical applications to the marriage and family field of research.

Definitions of Terms

For purposes of this study, *relationship violence* is defined as any unwanted physical, sexual, emotional, or financial control or power between two partners who are in an intimate relationship. Verbal aggression would be included in the definition of relationship violence.

Several terms are used in the literature to identify and describe family members affected by relationship violence. In particular, *offender* or *perpetrator* refers to the

person who has committed the crime of domestic violence. The terms *survivor* or *victim* are utilized in this study to identify a male or female adult who has experienced violence in an intimate relationship.

According to the Florida Statute 741.28-741.31,

> *Domestic violence* refers to any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit.
>
> *Family or household member* means spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who have a child in common, regardless of whether they have been married or have resided together at any time.

In feminist writing on the patriarchal structure and content of language, writers stress that women's experience is silenced and made invisible by the lack of words with which to name it (Daly, 1978; Spender, 1980). A major contribution of feminist social action around sexual violence has been to provide or create new terms with which to describe and name the experience. For example, the terms *battered woman* and *sexual harassment* did not exist 20 years ago. Even if a name exists and is known, the way it is understood can vary greatly. For example, feminists have challenged the limited traditional definitions of forms of sexual violence by expanding the definition of *rape* to include unwanted and/or forced intercourse between husband and wife and by including *psychological abuse* and *coercive sex* in the definition of domestic violence. Limited definitions tend to draw on stereotypes of forms of sexual violence, stressing particular features and ignoring others (Kelly, 1988).

In this study, *individual therapy* is used to describe sessions with an individual client alone, using individual techniques and theories of counseling. *Conjoint therapy* (or

couples therapy) is used to describe sessions with a couple or dyad together. *Group therapy* is used to describe therapy involving three or more clients and a counselor. *Family therapy* is used to describe a variety of counseling approaches that work with family members together in a session with a counselor.

The term *survey* is used to include cross-sectional and longitudinal studies using questionnaires or structured interviews for data collection with the intent of generalizing from a sample to a population (Babbie, 1990). A *variable* is a discrete phenomenon that can be measured or observed in two or more categories (Kerlinger, 1979). Psychologists use the term *construct* interchangeably with the term *variable*, according to Kerlinger. Variables could be gender, age, SES, or attitudes or behaviors such as racism, social control, political power, and socialization. Because the phenomena vary (in two or more categories), they are called variables (Creswell, 1994).

Organization of the Dissertation

Presented in chapter 2 is a review of the related literature, including an overview of relationship violence and the training of family therapists. Individual, group, conjoint, and family therapy treatment modalities are discussed as they apply to the population of this study. Presented in chapter 3 is a description of the methodology for the study, including the research design, sample, Internet survey, instruments, and data analysis. Chapter 4 presents a demographic description of the participants and results of factor analysis of the data. Chapter 5 presents an evaluation and discussion of the results, identifies the limitations of the study, discusses implications of the findings, and presents a conclusion to the study.

CHAPTER 2
REVIEW OF THE LITERATURE

To review what was stated in Chapter 1, this study will be organized around four points of research and literature review. They are (a) increase in incidence of relationship violence as indicated by statistics; (b) professional responsibility: legal, ethical, and therapeutic issues; (c) multiforms of treatment (metatheoretical, postmodernism, feminism, sociocultural, and social learning); and (d) identification of training needs.

Increase in Incidence of Relationship Violence

Violence in America has reached epidemic proportions and is exceeding the capacity and the responsibility of law enforcement alone to curtail it. Although still unacceptably high, overall criminal violence statistics have declined in recent years. However, the frequency and severity of violence against children, women, and the elderly are increasing at alarming rates. Between 1986 and 1993, reported cases of child abuse and neglect increased by 98%, while reported cases of elder abuse increased by 106%. It has been estimated that one woman in the United States is physically abused by her husband every 9 seconds (Heise, Ellsberg, & Gottenmoeller, 1999). Every day in the United States, four women murdered by male partners. This horrific fact is made worse by the realization that there are more women killed in acts of domestic violence in any 5-year period than all of the Americans killed in the Vietnam War (Berry, 1998).

Preventing violence and providing appropriate treatment for the victims of family violence are important concerns for the health care system and society. Training professional counselors in the current approaches to treating family violence is an area

that has recently drawn much attention. Incorporating family violence coursework into graduate training programs is an ethical decision with which each department is faced. The incidence of graduating students who are ill prepared to handle complex cases involving family violence does not serve future clients, the clinician, or the community in which the violence is occurring.

Interpersonal relationship violence has a long history as a deep-seated social phenomenon. Several social historians have documented the informal and formal sanctions that have encouraged wife battering (Davidson, 1978; Martin, 1976; Pleck, 1987). In early 19th-century America, a husband was permitted to discipline his wife physically without prosecution for assault and battery. The legendary "rule of thumb" law derived from English common law eventually restricted the instrument of wife beatings to a stick no thicker than the man's thumb. Only in the past 15 years have courts finally considered wife battering to be a criminal offense. These historical circumstances led several social scientists to explain that men batter women basically because they are permitted and encouraged to do so (Gelles, 1983).

Such "selective inattention," as it has been called (Pleck, Pleck, Grossman, & Bart, 1978), has important social implications. It was not until the women's movement in the 1970s identified and responded to wife battering that it emerged as a "social problem" (Tierney, 1982). Prior to this time, social scientists, physicians, social workers, psychologists, and clergy had virtually overlooked and even denied that wife battering existed. This markedly contrasted the extensive professional involvement in the issue of child battering (Finkelhor, 1983).

Feminists concluded that such negligence was a symptom of the sexist attitudes that pervade our society and contribute to relationship violence (Martin, 1976). According to the feminist analysis, wife battering is the rape, sexual harassment, incest, and pornography to which women are disproportionately subjected. To address this problem and compensate for what other social services and the criminal justice system have largely shunned, nearly 1,000 women's shelters were established across the country, largely through the grass roots efforts of the women's movement of the 1970s (Schechter, 1982).

While differences remain over the definition of battering and its dynamics, there is consensus that social services have inadequately responded to the problem. Clergy have been accused of promoting compliance and submission to the abusive man (Horton, 1988); physicians have tended to identify battered women as "troublesome" (Kurz, 1987); police have, for the most part, taken a "hands off " approach (Dolon, Hendricks, & Meagher, 1986); psychiatric staff are inclined to overmedicate battered women and return them to their spouses (Gondolf, 1990).

These deficiencies are reflected in the observations of battered women. A survey of formerly battered women rated women's shelters to be the most effective avenue in helping to end the violence. Lawyers were the next most helpful. Other forms of social service were, on the whole, rated as less than satisfactory (Bowker, L., 1983, 1986).

Partner violence has many causes. This is one of the reasons that there is no single solution. The major points discussed in this chapter are viewed through a multitude of lenses, including looking at power, sociocultural factors, worldwide prevalence of relationship violence, feminist views, social learning theory, and the social structure of

our society. Treatment philosophies and batterer's typologies are also discussed. Current literature is reviewed to identify risk factors for relationship violence.

Professional Responsibility: Legal, Ethical, and Therapeutic Issues

Licensing Boards

A skill deficit of the magnitude described above poses legal problems for licensing boards, accreditation boards, and academic and training institutions overseeing therapists. The various boards and institutions would theoretically be ethically and morally responsible to victims of family violence if therapists were not properly trained to assess and intervene in these specialized cases. Therefore, more training and specialized programs should be developed to meet the growing demand of family violence cases that professionals treat. Counselors are well trained to initiate screening for suicide but not as likely to screen for safety issues related to domestic violence (Jansinski & Williams, 1998).

Lack of Training in Family Violence

One reason for the lack of appropriate training in prevention and treatment of family violence is thought to be that professionals are uncomfortable in asking clients about possible violence. This discomfort is common and should be explored with counseling students during their training and supervision (Jansinski & Williams, 1998). A supervision practicum in family violence issues would make the training component more comprehensive; individual issues that face students regarding this issue could be discussed.

Counselor education programs should include in their curriculum a course in family violence or should address this theoretical approach in one or more core classes. Students should be informed regarding methods of family violence assessment and

should be given vignettes to test their level of mastery in this skill area. Such training should take place before students are made eligible for practicums or internships. Requirements such as these would better prepare students to treat family violence cases effectively.

Minimum State Requirements for Training

Currently, most states require a minimum of 2 hours in domestic violence training for licensure or professional credentialing. In 2003 California has led the way by increasing the minimum state requirement to 6 hours in domestic violence training. However, some state and profession licensing and credentialing bodies have no required training in the area of relationship violence.

In her article on training family therapists to assess for and intervene in partner abuse, Haddock (2002) summarized core assumptions regarding curriculum development in this area. First, feminist theoretical perspectives and treatment approaches are essential to the effective treatment of partner abuse; however, privileging feminist explanatory theories and treatment protocols do not disallow the inclusion of complementary theoretical explanations and approaches (Goldner, 1992, 1999). The second core assumption presented by Haddock was that therapists should be exposed to current developments, controversies, and inconsistencies in the theoretical literature; however, they also should be provided with specific principles, protocols, and skills to guide their clinical work. The third core assumption presented by Haddock was that, given therapists' tendency to reduce the inherent complexity of partner abuse cases in response to concerns about potential lethality, therapists should learn to conceptualize each case within its in own unique and multifaceted context (Dutton, 1992; Goldner, 1999), while attending to the intersections of gender, race, class, religion, and sexual

orientation (Bograd, 1999). The fourth core assumption presented by Haddock was that therapists should be cautioned to utilize the most conservative assessment and treatment approaches and to obtain direct and close supervision on cases involving partner abuse.

Theoretical Constructs Underlying the Study

Feminist View

Many different approaches are used when counseling battered women and perpetrators of relationship violence. One approach is the feminist approach, in which the batterer is viewed as being completely responsible for the battering. Feminists view the battering as a criminal act that is used to control, intimidate, and inflict harm (Goldner, 1999).

Walker (1995) particularly broadened the playing field by bringing in anecdotes about how to match certain types of batterers with specific psychotherapies. Given the sociopolitical context in which battering occurs, if psychotherapy is to be successful in the treatment of battering, it must be integrated within a community-wide response. This would involve coordination among therapists, police officers, probation officers, prosecutors, judges, and advocates. Walker (1995) claimed that the Duluth model (Pence & Paymar, 1993) is particularly promising, since treatment includes attention to the entire social context of battering through community organizing.

Feminist theory has also been used as a conceptual framework for explaining the presence of violence between males and females. In feminist theory, violence is viewed as a manifestation of the patriarchal structure in our culture, which is reflected in the patterns of behaviors and attitudes of individuals (Gentemann, 1984; Kalmuss, 1984). As part of Lenore Walker's (1999) theorizing, violence against women in general has been conceptualized as gender-based; interventions are stressed by using advocacy, victim

services, and educational efforts. The feminist perspective on domestic violence is accepted worldwide. Where women and girls are primary targets of male abuse, violence cannot be eradicated without looking carefully at gender socialization issues that maintain and possibly facilitate such violence in the home.

The incorporation of social justice perspectives into family therapy training, practice, and research has been a recent focus of family therapy scholarship (Bograd, 1999; Haddock, Zimmerman, & MacPhee, 2000; McGoldrick et al., 1999). These authors have focused on intersections of race, class, sexual orientation, and gender as they relate to the training and practice of family therapy. Goldner (1988) recognized that both age and gender organize families, and she implored family therapists to reduce power differentials based on gender within family therapy.

Feminist therapists claim that a therapist who does not directly challenge power and control based on traditional gender hierarchies contributes to the maintenance of unjust power differentials between men and women (Avis, 1996; Goldner, 1988; Hare-Mustin, 1987; Walters, Carter, Papp, & Silverstein, 1988). These feminist scholars urge therapists to challenge powerful acts by men over women and to expose gender hierarchies by calling attention to them in therapy. As Hardy (2000) pointed out, family therapists are often guilty of allowing the most powerful members of society to continue speaking while inadvertently silencing those with less power. To heal strained relationships, we must let the oppressed have an opportunity to speak during therapy that takes the needs of all family members into account.

The Study of Power

In his 1993 book *Understanding Family Process*, Broderick organized family process literature, which he called "relational space," into three major areas: (a)

regulation of interpersonal distance, (b) regulation of interpersonal transactions, and (c) regulation of "vertical space," by which he meant power. The idea of "regulation" implied a homeostatic set point theory. In a therapy context, these three areas were respectively discussed as positivity/caring, responsiveness, and status/influence (Gottman, Notarius, Gonso, & Markman, 1976).

Historically, the regulation of interpersonal distance was first explored by examining the clarity of communication. Hypotheses were advanced to explore the role of unclear communication in dysfunctional families and family distress. More specific hypotheses were advanced that unclear communication was responsible for psychopathology (Bateson, Jackson, Haley, & Weakland, 1956; Watzlawick, Beavin, & Jackson, 1967), and the cybernetic model or the systems approach to family process was born.

In their decade review of observing marital interactions, Gottman and Notarius (2000) stated that historical research was complex but included the result that balance in husband-wife power was related to marital quality; however, self-report and observational measures did not show a high level of agreement in classifying couples. These researchers stated that the issues of blending the study of affect and power are central to the integration of psychological and sociological approaches to marriage.

Power is now being studied more precisely, using coding of the couple's influence patterns during a discussion of the Inventory of Marital Conflicts (Olson & Ryder, 1970) used by Gray-Little, Baucom, and Hamby (1996). They found that egalitarian couples had the highest "Time 1" marital satisfaction and fewer negative marital inventory conflicts scale behaviors. Power is also being explored in the context of gender and

relational hierarchy. Feminist writers have pointed to the central role that power must play in understanding marriages. Quantitative observational research has now begun to explore these ideas (Gottman & Notatius, 2001).

Equipped with a sound theoretical basis for addressing intimate violence in a couple format, feminist family therapists have continued to develop couple approaches that are sensitive to issues of power and gender (Almeida & Durkin, 1999; Bograd & Mederos, 1999; Greenspun, 2000; Jory & Anderson, 2000; Lipchik & Kubicki, 1996; Shamai, 1996). Hardy (2000) cautioned that the most powerful members of society continue to speak while inadvertently silencing those with less power.

Social Learning Theory

Research by Alexander, Moore, and Alexander (1991) applied social learning theory to investigate the intergenerational transmission of violence among dating partners. This perspective explains that a man's involvement in dating violence is best predicted by a personal history of severe abuse by his father. Although his behavior is not directly predicted by having witnessed violence between his parents, his attitude toward women apparently is thus predicted. His own attitudes are relevant to the perpetration of violence only as they interact with those of his partners.

Scientists have traditionally believed that experiencing physical abuse as a child increases the risk of later aggressive behaviors, based on social learning theory (Bandura, 1973). Social learning theory proposes that people acquire novel behaviors and expand personal behavior repertoires by observing others' behaviors as well as through classical and operant conditioning (Bandura, 1965, 1973). They observe other individuals and use imitation to perform novel behaviors.

To imitate a behavior, the person must have some motivation or incentive for doing so. Incentives are what the person expects to obtain once the behavior is performed. Incentives act as reinforcers. When incentives are available, observation is more quickly translated into action. Incentives also influence the attention and retention processes. Children pay attention when given incentives to do so and, with more attention, more information is retained. In the Bobo doll experiment, some children witnessed the adult being rewarded for aggression. Therefore, these children performed the same act to achieve the same rewards (Bandura, 1977).

Bandura asserted that people can also learn new behaviors without practice and without reinforcement. Simply stated, an observer may copy a model's behavior long after he or she saw the action performed, even without any immediate reinforcement being earned by the model or the observer. Researchers have begun to consider the role of previous abuse and violence on propensity for victimization, although only very limited data have supported this theory; indeed, myriad unanswered questions remain.

Social learning theory not only deals with learning but also seeks to describe how a group of social and personal competencies (i.e., personality) could evolve out of social conditions within which learning occurs. It also addresses techniques of personality assessment and behavior modification in clinical and educational settings (Bandura, 1977).

Social learning theory not only deals with learning but also seeks to describe how a group of social and personal competencies (i.e., personality) could evolve out of social conditions within which learning occurs. It also addresses techniques of personality

assessment and behavior modification in clinical and educational settings (Bandura, 1977).

Further, the principles of social learning theory have been applied to a wide range of social behaviors, including competitiveness, aggressiveness, sex roles, deviance, and pathological behavior (Bandura & Walters, 1963). Currently, it is impossible to ascertain the exact social cognitive processes at work or how the observation of violence translates into victim versus perpetrator status. The specific effect of social learning theory remains an unresolved issue (Lewis & Fremouw, 2001).

Lenore Walker studied some intriguing animal behavior theories based on laboratory research. She began to see startling connections between the coping mechanisms of battered women and the behavior of caged dogs subjected to random and variable electric shocks. "Learned helplessness" became one the linchpins of *The Battered Woman*, published by Harper and Row in 1979. Coining the phrase "battered women's syndrome," Walker delineated a common cycle of violence: a honeymoon period followed by a buildup of tension, followed by an explosion and battery, followed by regrets and apologies, followed by another honeymoon period, and so forth. By featuring stories of several professional women who had endured physical abuse in marriage, Walker put to rest the myth that battery was strictly a lower-class problem (Brownmiller, 1999).

Social Structural Theory

The social structural approach examines patterns first applied by Goode (1971), which applied Blood and Wolfe's (1960) resource theory of power to explain a husband's use of physical force against his wife. Goode maintained that violence is a resource, similar to money or personal attributes, that can be used to deter unwanted actions or to

induce desired behaviors. The use of violence thus can be seen as the most overt and effective means of husbands' social control over wives (Yllo & Bograd, 1988) in that it is used when other and more subtle methods of control do not lead to submission.

In a study by Allen and Straus (1980), key propositions of Goode's (1971) resource theory of violence were tested using occupational prestige, educational level, income, and satisfaction with income as measures of extrinsic resources. This study also used variables for assessing interpersonal, intrinsic resources. The researchers found a strong, positive correlation between the low resources/working class variable and the husband's use of physical force. This is consistent with other studies that have shown that husbands who experienced resource deprivation were more likely to physically abuse their wives (Bowker, L., 1983; Pagelow, 1981).

Around the world, state-sanctioned violence, such as civil and interstate wars, often increases the amount of violence against women; rape and brutal physical beatings of the enemy's women have been considered just the spoils of war. Better understanding of the relationships among civil war, domestic violence, and women's mental health is important to help countries to provide both prevention and rehabilitation strategies (Walker, 1999).

Strong cultural traditions tying women to small communities with few resources (and power), state-sponsored conflicts, and greater acceptance of gender inequities all contribute to the greater risk for a woman to be battered in her home (Heise, 1994; Koss et al., 1994; Root, 1992; Walker, 1994).

An association in the marital literature between spouse abuse and self-esteem is well documented (Goldstein, 1985; Hotaling, 1988), with the level of self-esteem

negatively correlated with frequency and severity of violence (Cascardi & O'Leary, 1992). However, it is often unclear whether low self-esteem precipitates violence or is the result of chronic battering. Empirical support exists that low self-esteem contributes to the difficulty that victims experience in disengaging from an abusive marriage (Aguilar & Nightingale, 1994). As a result, low self-esteem may be associated with increased tolerance for interpersonal violence.

Treatment of Relationship Violence

Choice to Leave or to Stay in Abusive Relationships

The cognitive process that a victim undergoes when choosing to disengage from an abusive relationship provides important information with regard to victimology. Rosen and Stith (1995), employing a multiple-case qualitative research design, identified a progression of hierarchical cognitive steps utilized by individuals who eventually disengaged from abusers.

The process included a five-step progression of disengagement: (a) seeds of doubt, such as fleeting thoughts, often not identified until the dissolution of the relationship; (b) turning points, or events that significantly impacted the intimate relationship; (c) reappraisals, occurring when the victim re-evaluated the relationship; (d) paradigmatic shifts, which included a shift in perspective about the relationship; and (e) last straw events, or events providing the impetus to terminate the abusive relationship.

The explanations of why individuals remain in abusive relationships has traditionally focused on dispositional characteristics such as low self-esteem, learned helplessness, or masochistic personalities (Rusbult & Martz, 1995). A new model shifts the focus away from blaming the victim and examines the interdependent nature of ongoing relationships. This model proposes that victims apply a two-step model,

considering their resources and level of satisfaction when deciding to stay or leave an abusive relationship (Choice & Lamke, 1997). According to this model, an abused woman may stay in the relationship for several reasons. For example, she may experience feelings of satisfaction, believing her best available alternative to staying is not attractive enough to terminate the relationship. Second, she may believe that she has a strong emotional investment and, thus, does not feel ready to leave the relationship. This model is not proposing that victims want to be abused, but rather that some women choose to remain in a relationship despite the abuse (Lewis & Fremouw, 2001).

Rusbult and Martz (1995) provided additional support for the supposition that victims' decisions to stay in abusive relationships are influenced by environmental as well as intrapersonal variables. Researchers found that a victim's choice to remain in an abusive relationship was strongly related to level of satisfaction in the relationship, quality of alternatives, and size of the investment. These models (Choice & Lamke, 1997; Rusbult & Martz) represent a shift in conceptual understanding of the subtle nuances and dynamics of victimization. Additional research is needed to examine the conditions that trigger victims to leave abusive relationships. As described above, a variety of factors may predispose a couple to relationship violence.

Most likely, it is a combination of these factors that motivates a perpetrator to offend. A contemporary study of American couples conservatively documented that 1 in 8 husbands had committed a violent act against his wife during the preceding year. A comprehensive review of studies using probability samples revealed that the reported rate of wife abuse in the United States was between 11% and 22% (Straus & Gelles, 1990).

Gottman's Batterer Offender Typologies

Two distinct typologies are described by Gottman et al. (1995). In the 200 seriously violent couples studied, these researchers found at least two kinds of batterers: Type 1 ("cobras") and Type 2 ("pit bulls"). This research dealt primarily with the physiological response of male batterers to a high-conflict marital discussion. In this study, Type 1 men's heart rates lowered from baseline in response to the high-conflict marital discussion, while Type 2 men's heart rates increased from baseline. Type 2 refers to men whose emotions quickly boil over, whereas Type 1 refers to men who remain cool and methodical as they inflict pain and humiliation on their partners. This was evident in physiological data taken from heart monitors while participants had angry responses to their partners.

Type 2 men were referred to as "pit bulls." These men are characterized as having a quick temper and are physiologically aroused when behaving aggressively. Using the metaphor of the "pit bull," this type of dog is used in dog fights and is known as a vicious fighter that will often fight until death. These dogs become aroused and aggressive when other dogs are being aggressive. The "pit bulls" or Type 2 men scrutinize their wives and display excessive need for approval and self-fulfillment.

According to Gottman et al. (1995), the Type 1 batterer is referred to as the "cobra." Most striking is the swift escalation of anger and violence displayed by these men during a disagreement, again relating to the analogy of the cobra snake, which is swift and dangerous.

The "cobra" men enjoy shocking and scaring people. They are opposite to the "pit bulls" in that they are not worried or jealous, nor are they emotionally dependent. The significant finding of the Gottman et al. (1995) research was that "the cobra" offender's

heart rate actually got lower during an argument. Internally, these men remain calm, yet they are externally more violent and severe in their violence than the "pit bulls."

Jacobson and Gottman (1998) discussed the pit bulls and cobras further. They concluded that these two batterer types resemble dysphoric/borderline batterers and generally violent/antisocial batterers, respectively (Holtzworth-Munroe et al., 2000). Although Jacobson and Gottman focused their study on severely violent men, they also discovered what they called a "low-level violent" group of couples, which they followed with the expectation of tracking the development of violence from minor to more severe forms. Unexpectedly, however, this group almost never escalated their use of violence, and they were described by Jacobson and Gottman as a "stable group of couples who periodically have arguments that escalate into pushing and shoving, but never reach the point where we could call the men batterers" (p. 25). This description coincides with Johnson's (1995) description of common couple violence.

Overall, findings across research by Gottman et al. (1995), Meehan, Holtzworth-Munroe, and Herron (2001), and Babcock, Yerrington, Green, and Miller (2001) do not lend strong support to the Type 1-Type 2 batterer typology. Although severely violent men can be split into two groups on the basis of heart rate reactivity, so can both less violent and nonviolent men, raising questions about the theoretical meaning of this distinction. In addition, consistent differences between Type 1 and Type 2 severely violent men have not been found across studies.

Human Heart Reactivity

A review of previous research suggests that the use of human heart reactivity (HRR) may prove useful for differentiating male batterers on the dimension of

anger/hostility. There is less evidence that this approach will be effective for studying antisocial personality in these men.

Meehan et al. (2001) failed to replicate the batterer typology proposed by the Gottman et al. (1995) article. Therefore, caution is advised when discussing possible implications of these studies for public policy and clinical application. To be appropriately cautious, it should be noted that the Gottman et al. (1995) typology was supported in one study (i.e., their initial study) but was not supported in another study (i.e., the Meehan et al. study). Such an even scoreboard suggests that further attempts at replication are necessary before definitive conclusions may be drawn about the validity of the Gottman et al. typology.

It is possible that the Gottman et al. (1995) typology will remain a valid one after further scrutiny; therefore, clinicians and public policy makers should not abandon the idea of batterer typologies altogether. Indeed, across multiple research laboratories, there is increasing convergence regarding the descriptive and theoretical dimensions that can be used to meaningfully categorize variability among samples of batterers.

Holtzworth-Munroe and Stuart's Three Major Types of Batterers

Other research on men who batter women has suggested that there are three major types of batterers: (a) those who use violence as a strategy to gain power and control within their family, (b) those who use violence as a strategy and are also mentally ill, and (c) those who have serious personality flaws that permit them to use violence to commit other criminal acts as well as to abuse their partners (Dutton, 1995; Holtzworth-Munroe & Stuart, 1994; Jacobson & Gottman, 1998; Meloy, 1998; Saunders, 1992; Walker & Meloy, 1998).

Although other typologies for differentiating male batterers have been proposed, research on female perpetrators is much less extensive. Holtzworth-Munroe and Stuart (1994) proposed three types of male batterers: family-only, dysphoric/borderline, and generally violent/antisocial. Batterers can be identified along three descriptive dimensions: severity/frequency of violence, generality of violence, and psychopathology or personality disorders, as well as by risk factors correlated with the development of violent behavior (such as witnessing violence in the family of origin). Dysphoric/borderline and generally violent/antisocial batterers engage in moderate to severe levels of violence, and the latter are most likely to be involved in criminal behavior and use violence both within and outside the home. The dysphoric/borderline batterers tend to confine their violence to the intimate relationship. Family-only batterers engage in the least amount of violence, show little or no psychopathology, and have very low levels of risk factors. Empirical testing of the model has supported this batterer typology (Hamberger, Lohr, Bonge, & Tolin, 1996; Holtzworth-Munroe et al., 2000; Tweed & Dutton, 1998; Waltz et al., 2000).

Identification of Training Needs

Current Status of Training and Need for Additional Curriculum

There was a time when learning one particular school of therapy was deemed sufficient empowerment to treat all manner of clients—or at least sufficient to make one feel prepared to treat all types of clients. With time, specific treatments began to be developed for particular problems. Alcoholism became widely recognized as a problem that necessitated a particular type of therapy. Phobias were found to respond best to behavioral treatment. Treatment began to be problem specific rather than school oriented. Added to this is a new pressure: the necessity of keeping up in a field where,

seemingly, every new day reveals a new type of therapy for a new type of problem (Salter, 1988). The treatment of family violence as well as child sexual abuse offenders and victims has only recently evolved into a specialized field. Although for many years there have been specialized treatment programs available in a few states, the need to set up more specialized treatment programs in every state has only recently been recognized.

This recognition has been spurred by two factors: (a) the increasingly widespread acknowledgement of the extent of the problem, and (b) the increasing acceptance that traditional forms of therapy are not effective with this population (Crawford, 1981). However, specialized treatment does appear to have an impact (Knopp, 1984).

Continuing Education Units

Academic institutions, institutes, workshops, and continuing education credits are responsible for the successful dissemination of academic knowledge pertinent to the profession. These educational areas must provide an integrated course of study as well as appropriate professional training. An ethical education program with quality is one that uses traditional and managed care approaches of training emphasizing the current theories of practice and those presented in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) of the American Psychiatric Association (1994). It should be a program that develops competency in people working with diverse aspects of society, resulting in effective, cost-efficient treatment plans and service delivery. Only recently (in 1995), California began specialized spousal abuse training for marriage and family therapists. Psychologists are required to have coursework in human sexuality, chemical and substance abuse, and child abuse.

However, spousal abuse training is not currently a requirement for licensing in California or in many other states. Both trainees and interns are permitted to perform

counseling in a governmental entity, school, college, university, nonprofit agency, charitable corporation, or licensed health facility under the direct supervision of a licensed supervisor, regardless of whether that supervisor has received specialized training in the area of spousal abuse (Board of Behavioral Science Examiners [BBSE], 2000).

Skills in Assessing Relationship Violence and Imminent Danger

In previous research there is a precedent for needed improvement in the education and training of psychotherapists. Hansen et al. (1991) surveyed members of a marriage and family therapy organization. The therapists in this survey were asked to read two vignettes with proven therapeutic interventions for domestic violence cases. These cases portrayed female victims and domestic violence. The results indicated that the counselors did not attend to the seriousness of the violence portrayed in the vignettes, and many did not attend to the violence at all. As a group, the therapists did not attend to the crisis nature of the cases portrayed and failed to intervene for needed protection of female victims from their batterers. Forty-one percent of the therapists surveyed indicated no recognition of domestic violence. Interventions provided by therapists in this study were also negligent with regard to violence potential. For example, 55% of respondents reported that they would not intervene even when the violence portrayed required immediate action. Only 2% reported a potential for lethality in these cases. A scant 11% of the respondents indicated that they would obtain protection for the wife by helping her to develop a safety plan, obtain shelter, or obtain a restraining order.

Psychologists were significantly less likely than other respondents to conceptualize the case in terms of conflict or to describe the problem as violence. Because few counseling or clinical psychology graduate programs provide academic or clinical

exposure to the problem of domestic violence presently (and even fewer have done so in the past), there is reason to expect that knowledge and skill deficits similar to those observed among physicians and family therapists in the Hansen et al. study might be found among practicing psychologists as well (Carden, 1994).

Assessing for Risk Factors Associated With Relationship Violence

Riggs, Caulfield, and Street (2000) discussed the need for identifying risk factors for domestic violence. They stated that the extent and potential dangerousness of the problem of domestic violence warrant systematic screening and assessment in all mental health settings. Few empirical studies have approached the question of domestic violence with the aim of identifying risk markers, making it impossible to identify persons at risk for perpetrating or becoming victims of domestic violence.

Identifying Risk Factors Associated With Relationship Violence

A number of factors have been identified as correlates of domestic violence that may eventually prove useful for identifying persons at risk. However, existent literature does not provide empirical support for these factors. Identifying factors that might assist clinicians in the recognition of clients who are at risk for domestic violence would help clinicians to attend appropriately to this potentially dangerous problem.

Ongoing assessment in the context of knowledge regarding correlates of domestic violence can provide important information for evaluating risk of a particular violent incident. In addition, strategies for assessing violence and violence risk in both perpetrators and victims can assist clinicians in approaching this difficult topic in a clinical setting. A careful assessment of the potential for violence within clients' ongoing relationships is necessary for clinicians to provide appropriate care (Riggs et al., 2000).

Prior Relationship Aggression

One of the primary risk factors for perpetrating violence against a spouse or significant other is having committed such violence against that same person previously. Rarely, if ever, does an incident of spouse abuse occur in isolation; typically, violence occurs throughout the relationship. In a longitudinal study of violence within marriages, O'Leary et al. (1989) examined couples engaged to be married and followed them for 3 years. These researchers found that violence was relatively stable over the first few years of marriage. For example, of men who perpetrated aggression prior to marriage, 51% also had engaged in aggression during the first 18 months after marriage. In comparison, the probability of a man who was not aggressive prior to marriage being aggressive 18 months into the marriage was 15%.

In another study of engaged and newly married couples, men who perpetrated violence against their partners prior to the wedding were significantly more likely than were men with no history of relationship violence to perpetrate violence within the following year (Leonard & Senchak, 1996). Examining more established relationships, Feld and Straus (1989) found that frequency of self-reported aggression was predictive of aggression in the ensuing year: Almost 50% of men who had been violent prior to the initial assessment in the study engaged in violence in the following year. In comparison, only 10% of those who had not been violent prior to the initial assessment engaged in violence in the following year.

Demographic Characteristics

Rates of domestic violence tend to decrease slightly as the age of couples increases (Straus et al., 1980). Other demographic risk factors for marital violence appear to be related to increased stress in the family. For example, men of lower SES are at an

increased risk for perpetrating domestic violence and tend to perpetrate more severe violence than higher-SES counterparts. Similarly, men who are unemployed appear to be at an increased risk for perpetration of spouse abuse.

National surveys suggest that men of color are at an increased risk, compared to Caucasian men, for perpetrating violence against their wives and partners. However, this difference appears to be at least partially the result of different SES levels in White and minority samples (Holtzworth-Munroe et al., 1996).

Psychological Characteristics

Men who have perpetrated violence against a spouse tend to differ from those who have not done so on a number of psychological constructs. Many of these factors, according to Riggs et al. (2000), are of theoretical interest for understanding why spouse abuse occurs and may be helpful in identifying men at risk for such violence. For example, spouse abusers tended to be more angry and hostile in general than their nonabusive counterparts (Eckhardt, Barbour, & Stuart, 1997). Further, when confronted with marital conflict situations, abusive men tended to be less assertive and respond more with anger and hostility than nonviolent men. Particular topics of conflict such as jealousy and threats of abandonment may have exacerbated this pattern of response (Holtzworth-Munroe & Anglin, 1991). This latter finding fits with research that identifies fear of abandonment as an important aspect of abusive men's behavior (Dutton, Saunders, Starzomski, & Bartholomew, 1994) and may serve to identify specific points in time when the risk of spouse abuse is particularly high. Unfortunately, few of these variables have been investigated in ways that translate the findings into specific indicators of risk.

Specific Psychological Syndromes

Post Traumatic Stress Disorder (PTSD). Researchers have linked men's symptoms of depression, PTSD, borderline personality disorder, and substance abuse to the perpetration of violence against their wives and partners. Important with regard to the present discussion, some of these syndromes have been examined as risk factors rather than simply as correlates of marital violence. Thus, they may serve as useful markers or risk factors of future perpetration.

Researchers have examined the link between symptoms of PTSD and the perpetration of marital violence. Studies in this area indicate that men with PTSD are at considerable risk for perpetrating marital violence. Jordan et al. (1992) found that wives of Vietnam veterans with PTSD were about twice as likely (30%) as wives of veterans without PTSD (15%) to report that their husbands had engaged in marital violence.

Depression. Depressive symptoms have been related to the perpetration of marital violence in a number of studies (Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988; Pan, Neidig, & O'Leary, 1994). Generally speaking, men who are aggressive toward their wives exhibit more depressive symptoms than do nonaggressive men. For example, in one study, significantly more abusive men, as compared to a nonabusive group, scored within the depressed range of the Beck Depression Inventory (Maiuro et al.). Higher scores on this inventory have also been related to violence in couples seeking marital therapy (Vivian & Malone, 1997) and in general population samples (Pan et al.).

Substance abuse. The rates of spouse abuse among men diagnosed with substance abuse problems indicate that men with diagnosable alcohol problems are at substantially increased risk for spouse abuse (Gondolf & Foster, 1991; Leonard, Bromet, Parkinson, Day, & Ryan, 1985; Murphy & O'Farrell, 1994; Stith, Crossman, & Bischof, 1991). For

example, Leonard et al. found rates of marital aggression in men diagnosed with a current alcohol problem (44%) to be about 3 times greater than in men without an alcohol use disorder (15%) or a past alcohol problem (14%). Murphy and O'Farrell reported that about two thirds of a sample of married male treatment-seeking alcoholics had engaged in marital violence.

Borderline personality disorder. Another disorder that has been linked to the perpetration of spouse abuse is borderline personality disorder. This disorder is characterized by identity issues that become salient in intimate relationships and that vary on three defining features: identity diffusion, primitive defenses, and reality testing. Studies have found that abusive men score higher on measures of borderline personality disorder than do nonabusive men and that, among men who assault their wives, more severe violence is associated with higher levels of borderline personality disorder (Dutton, Starzomski, & Ryan, 1996).

Other Risk Factors

Marital dissatisfaction. As a group, men who perpetrate violence against their partners are less satisfied with their relationships than are nonviolent men (Alderondo & Sugarman, 1996; Hotaling & Sugarman, 1986; Sugarman & Hotaling, 1989).

Witness to spouse abuse or victim of child abuse. Many studies have found that men who perpetrated violence against their wives were more likely than men in nonviolent comparison groups to report that they had experienced violence in the family of origin, either as a witness to spouse abuse or as the victim of child abuse (Alderondo & Sugarman, 1996; Dutton & Hart, 1992; Hotaling & Sugarman, 1986; Kalmuss, 1984; Sugarman & Hotaling, 1989).

Previous head injury. Rosenbaum et al. (1994) documented a link between a history of head injuries and the perpetration of spouse abuse. In one study, these researchers found that men in treatment for abusing their wives reported a significantly higher rate of head injuries than did a group of nonabusive men.

Ability to Assess Violence Risk

Otto (2000) spoke to the importance of the mental health practitioner having the ability to assess violence risk in clients. The perception that persons with mental illness are at increased risk for violence, as compared to their non-mentally ill counterparts, can be dated at least to the time of Plato (Monahan, 1992). Indeed, among the rationales offered for establishing some of the first public psychiatric hospitals in this country was the need to protect the public by confining persons with mental illness who posed a risk of violence to the community. Flowing logically from the belief that there was a connection between violence and mental disorders was the assumption that mental health professionals, as a function of their expertise, were uniquely able to identify and treat persons whose emotional functioning increased their risk for violence, and could thereby reduce such risk (Otto).

Violence Risk Assessment Study

In response to the above, Monahan (1984, 1988) identified limitations of research examining the relationship between mental disorders and violence, as well as mental health professionals' abilities to assess violence risk. Due to these limitations, Monahan called for a "second generation" of investigations to better address these issues. This call resulted in a series of studies (Monahan & Steadman, 1994, for summary) and review articles (Mossman, 1994; Otto, 1992, 1994) and formed the basis for the Violence Risk Assessment Study organized by John Monahan under the auspices of the MacArthur

Research Network on Mental Health and the Law. Findings from this "second generation" of research, which incorporated many of Monahan's (1984, 1988) recommendations, suggest the following: (a) violent behavior is not necessarily a low base rate behavior and occurs with some degree of frequency among persons with mental disorder (Otto, 1992; Steadman et al., 1998; Wessely & Taylor, 1991); (b) persons with certain mental disorders and symptom clusters are more likely to engage in violent behavior than are persons without such disorders or symptom clusters (Swanson, 1994; Swanson, Holzer, Ganzu, & Jono, 1990); and (c) mental health professionals have some ability to assess violence risk among persons with mental disorders (Mossman; Mulvey & Lidz, 1998; Otto, 1992, 1994).

Assessing and Managing Risk

It is this body of developing research, along with research examining violence risk factors among criminal and nonclinical populations, that provides direction for clinicians faced with the task of assessing and managing risk with their clients. Although one might question whether findings from one population are applicable to other populations, a meta-analysis by Bonta, Law, and Hanson (1998) provides some support for the claim that risk factors for violent behavior may be similar across populations.

It should be no surprise to even beginning clinicians that more remains unknown than known about risk factors for violence among persons with mental disorders. Good practice requires that clinicians familiarize themselves with relevant literature and use informed clinical judgment in cases for which research literature provides no direction (Otto, 2000).

HCR-20 Item Risk Assessment Instrument

Use of a structured, guided clinical assessment developed in light of the extant research, such as HCR-20 (Webster, Douglas, Eaves, & Hart, 1997) can help to form the basis of a comprehensive evaluation that assesses factors relevant to violence risk. The HCR-20 directs clinicians to cover a total of 20 areas considered to be relevant to violence risk: 10 historical items, 5 clinical items, and 5 risk management items. Preliminary data indicate that the HCR-20 can be reliably scored (Belfrage, 1998; Douglas, & Webster, 1999; Ross, Hart, & Webster, 1998) and has some predictive power when compared to other risk assessment instruments.

Static and Dynamic Risk

Otto (2000) stated that, broadly speaking, risk factors for violence among persons with mental disorders fall into one of two categories. Static risk factors are those that either cannot be changed (e.g., age, gender) or are not particularly amenable to change (e.g., psychopathic personality structure). Identification of these factors is important in terms of identifying the client's absolute or relative level of risk; however, these factors typically have few implications for treatment or management of risk, since the factors, by definition, cannot be changed. In contrast, dynamic risk factors are those that are amenable to change (e.g., substance abuse, psychotic symptomatology). Identification of these factors is important, both in terms of estimating the client's absolute or relative level of risk and for purposes of treatment planning.

Hanson (1998) made a similar distinction: between stable dynamic factors and acute dynamic factors. Stable dynamic factors can change but have some enduring quality over time and across situations (e.g., deviant sexual preferences or alcoholism), whereas acute dynamic factors (e.g., sexual arousal or alcohol intoxication) are "states"

which can change much more rapidly. Assessing the former category may be more important for treatment planning and intervention planning when dealing with persons for whom there are concerns for violence in the future, while the latter category may be more important in terms of assessing imminent risk and making decisions about immediate interventions.

Conclusion

Feminist writings have focused attention on domestic violence and challenged the assumptions of approaches that blame women for their victimization. They support both the growing emphasis on interdependence and mutuality, rather than on autonomy and differentiation, in couple relationships and they focus on a more collaborative respectful relationship with clients (Luepnitz, 1988).

Graduate counselor education programs would ethically be fulfilling their ethical code and accreditation standards by including in their curriculum a course in family violence. Students would benefit by being informed regarding methods of family violence assessment and could be given vignettes to test their level of mastery in this skill area. Such training preparation could take place before students are made eligible for practicums or internships. Requirements such as these would better prepare students to treat family violence cases effectively.

Various intervention models are used in treating relationship violence. According to Harrell (1991), the short-term, court-ordered, batterer-only psychoeducational model had a high rate of recidivism, along with increased amounts of psychological abuse. Edleson and Grusznski (1988) and Pence and Paymar (1993) found better results from the short-term psychoeducational model used in the Domestic Abuse Project in Duluth, Minnesota. On the other hand, Dutton (1995) and Hamberger and Ambuel (1997) found

that interventions having the best results in stopping men from using violence were those that required attendance for a minimum of 2 years. Dutton's research suggests that many batterers have serious mental illnesses in addition to problems with power and control that underlie their use of violence (Walker, 1999). O'Leary (1993) and Geffner (1995) found that special techniques in family psychotherapy can be effective in helping to stop violence in the family.

Corsi (1999) developed a model that appears to incorporate the best features from available programs and is easy to apply across cultures due to its ecological approach (Walker, 1999). The recommended treatment approach begins with individual counseling for all parties and then marital and dyad sessions, in addition to family and group sessions (Giarretto, 1976).

Violence in close relationships is now acknowledged as a highly significant issue across diverse cultural groups (Walker, 1999). The underreporting of couple violence, even in couple therapy, is a major finding that has emerged over the past decade. One line of research has differentiated different patters of violent behavior, distinguishing those patterns that are more or less likely to be amenable to treatment (Jacobson & Gottman, 1998). Such research may assist the couple therapist in determining when and how to intervene.

In general, assessment procedures, risk factors, and treatment feasibility issues in violent relationships are now beginning to be addressed (Bograd & Mederos, 1999; Holtzworth-Munroe, Beatty, & Anglin, 1995). Well-defined assessment procedures (Bograd & Mederos) and differentiated treatment strategies are essential for client safety. All couple therapists must know how to identify and address patterns of violence, ranging

from verbal intimidation and threats to coercion and battering, and they must be able to make informed decisions about the best interventions to use in particular cases (Johnson & Lebow, 2000).

This literature review would be appropriate for an audience including mental health practitioners, faculty, health care workers, trauma and crisis center employees, domestic violence workers, parents, educators, and law enforcement personnel.

CHAPTER 3
METHODOLOGY

Relationship violence is a problem of extensive proportions in America. There are several theoretical models for assessing and treating violence survivors in order to prevent continuing abuse. However, it is unknown which treatment methods, assessment questions, and prevention models are actually put into practice with this population. Therefore, the primary purpose of this study was (a) to determine the factors that are most frequently reported by MFTs to be related to the identification, assessment, and treatment of relationship violence; (b) to measure how therapists, supervisors, and faculty members in marriage and family therapy rate themselves on their competence in the identification, assessment and treatment of relationship violence; and (c) to measure their rating of the importance of certain competencies and skills in the identification, assessment, and treatment of relationship violence.

These purposes were accomplished by examining two variables via the survey. The first variable, *Quality of Graduate Training*, was assigned two subscales, each with five items in the survey. The first subscale, *Knowledge*, was measured by five items eliciting *respondents' self-rating of their knowledge in relationship violence*. The second subscale, *Graduate Training Received*, was measured by five items asking respondents to *rate the graduate training that they received in relationship violence*. The second variable, *Competencies in the Identification, Assessment, and Treatment of Relationship Violence*, was measured by 10 items asking respondents to rate the importance of certain competencies identified by the researcher as directly related to this variable.

In an attempt to clarify some of the unresolved problems in the existing literature, this study was designed to answer the following questions:

1. *How do MFTs rate themselves on their knowledge in the identification, assessment, and treatment of relationship violence?*

2. *How do MFTs rate their graduate training in the identification, assessment, and treatment of relationship violence?*

3. *How do MFTs rate the importance of specified competencies and skills in the identification, assessment, and treatment of relationship violence?*

The significance of this study was discussed in chapters 1 and 2, based on (a) the increase in incidence of relationship violence as indicated by statistics; (b) professional responsibility: legal, ethical, and therapeutic issues; (c) multiple forms of treatment (metatheoretical, postmodernism, feminism, sociocultural, and social learning); and (d) identification of training needs.

The research methodology is described in this chapter. Included are descriptions of the research method, survey design, rating scales in the social sciences, research procedures, sample, sources of error in Web-based designs, survey research, research barriers, and limitations in relationship violence.

Research Method

Approximately 1,000 active members of AAMFT from various geographic regions of the United States were asked to participate in the research (appendix D). The RVTS was used to collect demographic data, including the professional counselor's age, gender, ethnicity, marital status, and highest academic degree.

This study was conducted using a Web-based survey sent to therapists, approved supervisors, and faculty members in marriage and family therapy. An exploratory factor

analysis was used to identify the related factors of training in the identification, assessment, and treatment of relationship violence as reported by MFTs.

A preliminary self-designed survey instrument (RVTS) was developed based on clinical expertise and research reviews. The model's elements were refined, based on field testing suggestions offered by 10 colleagues with practice expertise and research backgrounds. These colleagues were recruited based on their expertise in the areas of measurement, relationship violence, and family therapy, which included experience in teaching assessment and prevention of relationship violence. Certain variables were selected over others for the instrument, based on research and clinical knowledge. A panel of experts in the field reviewed the variables, and a revised selection was made based on their feedback on the items. This testing was important in establishing validity of the instrument and served to make improvements in the formatting and structure of the instrument.

This model was further refined based on a field study given to experts in the above areas. Results from the field studies were used to improve the model. Approximately 20% of the original items were deleted and another 20% were refined after feedback about the interpretation of items was given.

The exploratory factor analysis program was conducted on the basis of the researcher's specifications of the following items: (a) the variables to be factor analyzed; (b) whether the data were in raw form or in the form of a correlation or covariance matrix; (c) the number of factors to be extracted or the criteria by which to determine such a number; (d) whether the diagonal elements of the correlation matrix were to be replaced by communality estimates and, if so, what types of estimates were to be used;

(e) whether to employ orthogonal or oblique rotation; (f) the particular type of rotation to be used (Kim & Mueller, 1978); and (g) giving the extracted factors names that would be inclusive of all the items within that factor loading

Survey Design

In this section the prevalence of using surveys and rating scales in the social sciences is discussed. Rating scales and their relevance to the RVTS survey development are highlighted.

A survey design provides a quantitative or numeric description of some fraction of the population—the sample—through the data collection process of asking questions of people (Fowler, 1988). One goal of this data collection will be to generalize the findings on the current status of graduate training in relationship violence from a sample of responses to a population.

The data in this study were collected and compared via a Web-based survey system that scored responses electronically. Data from the individual marriage and family therapists, approved supervisors, and faculty members were examined to identify factors in the assessment/training provided to marriage and family therapists at respective schools regarding relationship violence. Factors related to treatment of relationship violence were correlated. Since this is an exploratory factor analysis, identifying factors that are important in the training of marriage and family therapists in working with relationship violence was highlighted.

The purpose of survey research is to generalize from a sample to a population so that inferences can be made about some characteristic, attitude, or behavior of this population (Babbie, 1990). Broadly, a sample is a part selected to represent a larger whole (Warwick & Lininger, 1975). The variables are the concepts or information in

which the researcher is interested. A questionnaire is a series of questions presented to the sample in person by an interviewer, over the telephone, via Internet, or via computer, through a self-administered Internet or Web-based instrument or in some other way. The data analyses and reports are then used to describe the group or to draw inferences about the variables, their relationships to each other, and their relationships to the population of interest (Nelson, 1996).

Surveys usually focus on people—facts about them or their opinions, attitudes, motivations, behaviors, and so on—and the relationship between variables under study related to these people. For example, survey research might be used to compare demographic characteristics of a sample of people in a particular location, their access to mental health services, and their perceptions about the efficacy of those services. This family therapy research could be used to make recommendations about improving the curriculum/training provided to marriage and family therapist in relationship violence.

These generalizations have been made in previous research. For example, in their 1989 survey research on family therapy Wetchler, Piercy, and Sprinkle surveyed both supervisors and supervisees about their impressions of their supervision experiences and made some suggestions about marriage and family therapy training based on responses to their survey.

Rating Scales in the Social Sciences

Various types of questionnaires are by far the most-used method of data collection in psychology and other social sciences, and almost all of them use rating scales as their primary response mode. Countless articles have followed the seminal work of authors such as Freyd (1923), Thurstone, (1928), and Likert (1932). A response scale should

fulfill psychometric standards of measurement quality as well as practicality criteria, such as comprehensibility for respondents and ease of use.

It has been recognized for many years that answers to self-administered questionnaires are influenced by the way in which the questions and answers are displayed on questionnaire pages (e.g., Rothwell, 1985; Smith, 1993; Wright & Barnard, 1975, 1978). However, scientific understanding of the natures of those effects is not well developed. Although it has been argued on theoretical grounds that visual layout and design make a difference in how people answer questionnaires (Jenkins & Dillman, 1997; Sless, 1994), little experimental evidence exists that changing the visual presentation of individual survey questions influences people's answers.

On occasion, rating scales are used in which verbal labels are compressed to saturate one end of the response continuum. In these scales, differences arise between the normal meaning of the label and its scalar position. In some instances, however, equally spaced options across the entire response continuum may not provide the desired properties in the measurements. For instance, Symonds (1931) recommended the use of evaluative rating scales of a set of labels that were packed with positive descriptions to overcome individuals' tendencies to be lenient in their description of others. For a 5-point rating scale, he recommended using the labels *Poor, Fair, Good, Very Good,* and *Excellent*. Guilford, in his classic *Psychometric Methods* (1936), reiterated Symonds's solution for the problem of errors of leniency. In addition, Guilford recommended that "in a similar manner in the numerical type of scale, the strength of the descriptive adjectives may be adjusted so as to counteract the error of central tendency" (p. 272).

French-Lazovik and Gibson (1984) also demonstrated that the labels used influenced the distribution parameters of rating scale data. By using more positive labels, they were able to systematically change the ratings in the predicted directions.

The meaning of the verbal label of a scale may depend upon the contexts of the label. One important context to be considered is the position of the label. Chase (1969) suggested that the meaning of the scale adjectives be determined by the relative position of the adjective in a group of response categories rather than by the "standard" definition of the scale labels. This suggestion was consistent with findings by Wildt and Mazis (1978) that both label and location had an impact on subjects' responses.

Klockars and Yamagishi (1988) found that the meaning of the labeled position was defined as a compromise between the label itself and the relative position. They showed results that suggested the use of rating scales containing verbal anchors predominantly from one end of a continuum to provide increased discrimination in the portion of the scale. This provides the respondent with response options that are more discriminating in one portion of the underlying continuum. Consequently, as stated by Worcester and Burns (1975), "The problem is not just that different words mean different things but that the same word can be made to mean different things as the context changes (p. 182)."

Usually, rating scales (*category scales* in psychometric terms) offer between 4 and 11 response alternatives (ordinal scale points which are supposed to be equidistant). Numbers or words or graphic symbols (or a combination thereof) can be used to denote the categories, but verbal labeling has become the dominant approach to facilitate communication (Rohrman, 2002). Instead of labeling every point on the scale, end points may be verbalized. In the Relationship Violence Training Survey (RVTS) instrument

constructed for this study a 6-point rating scale was used, with only the labels *Very Poor* and *Excellent* to define the two end positions for items 1-10 and *Not Important* and *Very Important* for items 11-20; intermediate positions were unlabeled. The respondent was allowed to discriminate between the two end points to define the meaning of the response without the judgment of labels used in other positions.

Research Procedures

The researcher requested permission and obtained approval from the University of Florida Institutional Review Board to proceed with the study as proposed. Following this approval, the researcher sent research packets to professional counselors across the United States who were active therapist members of AAMFT, approved supervisors, and COAMFTE graduate training program faculty members.

Informed consent was obtained from participants. The participants were given the option to refuse participation in the study. All participation was voluntary and confidential. The results from the study are summarized as group findings and will be available to participants who express an interest in the results. The individual responses of counselors were not reported to their institutions/agencies or anyone else. See appendix D for the letter of invitation to participate in the survey and the accompanying consent form.

Sample

The first in a series of three Internet Web-based RVTS was sent electronically to a random sample of licensed marriage and family therapists. The list of Internet mail addresses was obtained from the AAMFT. The second questionnaire in the RVTS series was sent to a random sample of marriage and family therapy faculty members who teach in training programs in major university settings. This list was generated from approved

marriage and family therapy training programs from the AAMFT organization branch COAMFTE, which monitors and credentials marriage and family therapy training programs. The third questionnaire in the RVTS series was sent to a random sample of AAMFT approved supervisors from a list obtained from the AAMFT organization, retrieved from their national list of approved supervisors.

The questionnaire requested information about demographic variables (age, gender, etc.) and information about education and training. Therapists, supervisors, and faculty members were asked to rate themselves, using a 6-point scale, on their knowledge of factors related to the identification, assessment, and treatment of cases relating to relationship violence. They were also asked to rate their marriage and family therapy graduate training in the identification, assessment, and treatment of violence. They were also asked to rate the importance of certain competencies identified by the researcher to be related to the identification, assessment, and treatment of relationship violence.

Due to the initial response rate on the electronic response (error rate or nonresponse rate), an electronic follow-up mailing (appendix E) was sent out 2 weeks after the first electronic mailing to those who had not responded, with a reminder announcement listing the Web site link for participants to contact to be involved in the survey.

Sources of Error in Sample Web Surveys

The remarkable power of a sample survey is its ability to estimate, with precision, the distribution of a characteristic in a defined population. In addition, that estimate can usually be made by surveying only a small portion of the population under study. Sample surveys are subject to four major sources of error, and each must be attended to in order to have confidence in the precision of the sample survey estimates (Groves, 1989). These errors are (a) coverage error, the result of all units in a defined population not having a

known nonzero probability of being included in the sample drawn to represent the population; (b) sampling error, the result of surveying a sample of the population rather than an entire population; (c) measurement error, the result of inaccurate responses that stem from poor question wording, poor interviewing, survey mode effects, and/or some aspect of the respondent's behavior; and (d) nonresponse error, the result of nonresponse from people in the sample, who, had they responded, might have provided different answers to the survey questions from those given by persons who responded to the survey (Dillman & Bowker, 2001).

All four of these sources of error are as applicable to the design and implementation of Web surveys as they are to mail interview surveys. However, the early implementation of Web surveys suggests that some aspects of error, and in particular coverage and nonresponse, have been mostly ignored. Sampling error, although not being neglected, is instead often inferred when it is not appropriate to do so. For example, many Web surveys are conducted using samples of convenience or availability, and thus depend heavily on the solicitation of volunteer respondents, as described by Bandilla (2001).

One of the basic assumptions in surveying is the recognition that, for simple random samples of a defined population, the precision of results is closely related to completed sample size, or the number of respondents. For example, simple random samples of 100 have a precision of ±10 percentage points, and those of 1,100-1,200 (the size commonly used for election survey prediction) have a precision of ±3 percentage points. Sampling error is decreased by about half when sample size is quadrupled. Thus, samples of several thousand are expected to have precision measure in tenths of a

percentage point, assuming no other sources of error. Large number of volunteers respondents, by themselves, have no meaning. Ignoring the need to define survey populations, select probability samples, and obtain high response rates together provide a major thereat to the validity of web surveys (Dillman & Bowker, 2001).

Regarding coverage error, using the Web to survey the general public remains quite limited. Moreover, Black and Hispanic households are about two fifths as likely to have Internet access as are White households, and rural Americans about half as likely to have access as urban Americans with comparable incomes. Nua Internet Surveys (1997) estimated that 179 million people, or about 3% of the world's populations, has been online at least once, and over 40% of U.S. households now own computers but only one quarter of all households have Internet access (National Telecommunication and Information Administration [NTIA], 1999).

However, this does not mean that researchers are unable to conduct scientifically valid Web surveys. Some populations—employees of certain organizations, members of professional organizations, certain types of businesses, students at many universities and colleges, and groups with high levels of education—do not exhibit large coverage problems. When nearly all members of a population have computers and Internet access, as is the case for many such groups, coverage is less of a problem.

Another serious source of potential error in Web surveys is the nonresponse problem associated with positing a Web questionnaire and inviting people to respond. Number of contacts (or call-backs) has always been a major influence on response rates to other survey methods, and the tool most depended upon to reduce nonresponse error. There is little doubt that procedures can be developed for achieving response rates to

Web surveys that are reasonably comparable with those obtained by other methods (Dillman, 2000).

The advent of Web surveying presents measurement challenges not previously faced by survey methodologists and for which research has not yet provided solutions. The enduring problem is that what the designer of a Web questionnaire sees on the screen may differ significantly from what some, and in other cases most, respondents see on their screens. Evaluation of the Web surveys located by D. Bowker (1999) revealed much variability in methods of construction. When tested on various levels and types of Web browsers, operating systems, screen configurations, and hardware, the visual stimulus of the survey items (i.e., physical placement and presentation) was often different from what had originally been intended by the designer.

Although measurement error effects represent one of the most serious threats to the conduct of quality Web surveys, they are also among the most easily addressed through various design controls by programmers. In the construction of this survey HyperText Markup Language (HTML) was used in conjunction with SurveyWiz©, a program that was originated by Michael Birnbaum in 1998 (Birnbaum, 2000). This program was recommended by Dr. Roger L. Worthington, Ph.D., from the Department of Educational and Counseling Psychology at the University of Missouri-Columbia while attending a Web-based research methods forum at the 2001 Southern Association for Counselor Education and Supervision (SACES) convention of the American Counseling Association in Athens, Georgia. Dr. Worthington shared some of his experiences and explained how he had enhanced the programming to alleviate some of the measurement errors mentioned in this section. Dr. Worthington encouraged development of the survey

for the present study using the SurveyWiz© formatting, as he believed that it would help greatly in coding and reducing error while working with the data set prior to running factor analysis.

During the survey development, the researcher worked closely with Mr. Gary Sipe from Stetson University CIT Media Services to learn how to run SurveyWiz© (Birnbaum, 2000) programming and how to set up the HTML documents. These files were edited each time a revision was made to the items on the survey and saved on a working clipboard and then resaved into the actual document. The final versions of all three surveys were then saved onto the Stetson University Secured Server under an HTML file reserved for the researcher as an adjunct professor. All responses to the survey were forwarded from the Stetson server automatically to the researcher's email address, where they were automatically coded by question number. One way of reducing nonrespondent errors in this study was that each respondent was automatically coded by response time and email address (appendix F). This assured that no respondent could submit responses more than once. This process also helped in sending nonresponse notices to the correct nonrespondents. Finally, the data were placed into a standard computer application spreadsheet and prepared for run through a leading computer software statistical analysis (Statistical Package for the Social Sciences®; SPSS, 1975) for the factor analysis and demographics.

Survey Research in Family Therapy

In family therapy research, many surveys have been designed to determine what clinicians think or do. Survey research has been used to ask clinicians about their use of assessment instruments (Boughner, Hayes, Bubenzer, & West, 1994), about how they act when faced with ethical dilemmas (Green & Hansen, 1989), about their preferred models

of therapy (Quinn & Davidson, 1984), about how they use or view their clinical training (Carter, 1989; Coleman, Myers Avis, & Turin, 1990; Keller, Huber, & Hardy, 1988) and admission and program requirements (O'Sullivan & Gilbert, 1989), as well as about issues related to ethnicity and gender in curricula (Coleman et al., 1990; Wilson & Stith, 1993). Students have been surveyed about their ethnic minority status as therapists in training (Wetchler, 1989; Wetchler et al., 1989). Supervisors have been asked about their training practices (Lewis & Rohrbaugh, 1989; Nichols, Nichols, & Hardy, 1990), about what they view as essential basic family therapy skills (Figley & Nelson, 1989; Nelson & Figley, 1990; Nelson, Heilbrun, & Figley, 1993), and about the essential elements of marriage and family therapy and its supervision (White & Russell, 95).

On occasion, the general population or a class of clients has been surveyed to determine their experience with a particular issue. Examples include wives' experiences of their husbands' post-traumatic stress symptoms or combat stress reactions (Solomon, Ott, & Roach, 1986), couples' experiences of marriage encounter weekends (Doherty, Lester, & Leigh, 1986), and the effects of differing wake-sleep patterns on marital relationships (Larson, Crane, & Smith, 1991). Halik, Rosenthal, and Pattison (1990) measured personal authority (Bray, Williamson, & Malon, 1984) of daughters of Jewish Holocaust survivors or immigrants. These examples of survey research pertain to family therapy by virtue of the factors measured, which are often easily extrapolated into family therapy interventions.

The research enterprise in family therapy has undergone two major transformations since its early investigations. In the first transformation the field moved from its impressionistic beginnings to an emphasis on quantitative and experimental research. It

also challenged family therapy researchers to develop reliable and valid measures, which in conjunction with respectable research designs, helped to gain credibility for a fledgling discipline in a skeptical clinical world (Sprenkle & Bischoff, 1995).

The second transformation involved a shift from a strict adherence to quantitative methods to incorporation and gradual acceptance of alternate methodologies, especially qualitative methods (Hoshmand, 1989; Moon, Dillon, & Sprenkle, 1990; Sprenkle & Bischoff, 1995). Critics also argued that family therapy had made its quantitative leap too soon, before clearly delineating what was meant by systemic constructs (Bednar, Burlingame, & Masters, 1988). Therefore, concepts were operationalized before they were truly understood and consequently seemed removed from clinical reality. This called for more attention to contextual variables (Atkinson, Heath, & Chenail, 1991).

In terms of practice, marriage and family therapists and other mental health professionals routinely assess violence potential for children and adolescents and make related management decisions in psychiatric emergency services, civil psychiatric hospitals, juvenile justice, and outpatient clinics. Each of these settings may have different policy requirements for the evaluations, the amount and quality of available information may vary, and the nature and decisional thresholds may differ. Each of these factors can influence the way in which the risk assessment is conducted. Aware of this diversity, this paper outlines some broad principles for violence risk assessment that may be useful for marriage and family therapists in assessing risk of general violent recidivism in various contexts.

In his article on risk assessment Borum discussed historical, clinical, and contextual categories as the factors that show the most robust empirical support. He stated that the

history of violence would include being a victim of abuse or marital conflict. In his clinical factors category he included substance abuse problems, mental or behavioral problems, lack of empathy/remorse and attitudes that support violence. Included in contextual factors were negative relationships, lack of social support, stress and losses, community disorganization, and availability of drugs (Borum, 2000).

Data Analyses

The statistical technique used in this study was an exploratory factor analysis (EFA). The variables operationalized in this study are summarized in Table 1. Validity and reliability of the RVTS instrument are discussed in this section.

The Nature of Factors

The purpose of factor analysis is to discern and to quantify the dimensions supposed to underlie mathematical entities, which can be thought of as a classificatory axis with respect to which the test in a battery can be "plotted." The greater the value of a test's co-ordinate, or loading, on a factor, the more important is that factor in accounting for the correlations between the test and other factors in the battery.

An exploratory factor analysis is mainly used as a means of exploring the underlying factor structure without prior specification of number of factors and their loadings. In this study the responses were extracted into factors of what was most commonly identified by the participants in the prevention, assessment, and treatment of relationship violence.

The common factor model incorporates several parameters worthy of review in this study. This term is not to be confused with the "common factor" theory across models within the marriage and family literature, which implies a common theory of ideas between different theoretical approaches. In this study, common factors were defined as

Table 1

Variables Used for the Relationship Violence Training Survey (RVTS)

Exploratory factor analysis variables	Variables
Quality of graduate training in the identification, assessment, and treatment of relationship violence as reported by Marriage and Family Therapists	**Rating my knowledge and skills in RV** Assessment and treatment in RV Working with gay and lesbian clients Obtaining restraining orders RV skills today versus 5 years ago RV screening in premarital counseling **Rating my graduate training received in RV** MFT graduate training programs overall MFT graduate training that I attended Intake/assessment of RV Treatment approaches Continuing education units in RV
Importance of competencies and skills in the identification, assessment, and treatment of relationship violence as reported by Marriage and Family Therapists	**Importance of competencies and skills** Self-knowledge in assessment skills Identifying/assessing imminent danger Performing protection assessments rating Recognizing batterer typologies Identifying client resources Recognizing signs and symptoms/ cycle of violence Assessing ethical standards Assessing through a multicultural model Identifying risk factors in relationship violence Recommending risk assessment/ instruments

Note. RV = relationship violence.

an unmeasured (or hypothetical) underlying variable that is the source of variation in at least two observed variables under consideration(Kim & Mueller, 1978).

Thurstone (1947) originally advocated the simple structure principle as reflecting truth about the psychology of cognition; this is where the concept originated. Thurstone,

at the time of the introduction of simple structure, explicitly regarded factoring as a scientific revival of an old, discredited, unscientific notion of the principle of parsimony to supplement the first, by which all of the correlations are explained by as few factors as possible and each correlation is explained with as few of those factors as possible.

Thurstone stated that factor analysis is a technique to show the correlation of all tests of mental ability. Thurstone found that all of the mental ability tests were positively correlated, indicating a common factor among them. The analysis indicated the following seven primary mental abilities: verbal, number, spatial, perceptual, memory, reasoning, and word fluency (Thurstone, 1947).

Spearman (1904) viewed factor analysis as a data reduction procedure whereby a matrix of obtained measurements of N individuals on n experimental variables is replaced by a smaller matrix of factor coefficients or loadings, relating every variable to each of r factors, each an underlying variable assumed to represent an ability or other kind of trait, which is conceived as a vector in r-dimensional space ($N > n > r$).

According to McDonald (1985), the factor is "most like" the variables that increase most rapidly as the factor score increases. It is unlike the variables with zero loadings, as these do not vary as the large factor varies, and least like those variables that have large negative regression weights on it (i.e., the variables that decrease most rapidly as the factor score increases).

Stages in a Factor Analysis

The factor analysis in the present study was conducted in three stages.

1. A matrix of correlation coefficients was generated for all of the variable combinations.

2. Factors were extracted from the correlation matrix. The most common method is called principal factors (often wrongly referred to as principal components extraction, hence, the abbreviation PC).

3. The factors (axes) were rotated to maximize the relationship between the variables and some of the factors. In this study a Promax rotation method was used. Promax is an oblique rotation method through which a simple structure is sought; factors are rotated without imposing the orthogonality condition (i.e., that they be kept at right angles), and resulting terminal factors are in general correlated with each other.

A fourth stage can be added in which the scores of each subject on each of the factors emerging from the analysis are calculated. It should be stressed that these factor scores are not the results of any actual test taken by the subjects; they are the estimates of the subjects' standings on the supposed latent variables that have emerged as mathematical axes from the factor analysis of the data set. Factor scores can be very useful, because they can subsequently be used as input for further statistical analysis.

In this research study it was deemed advisable to carry out only the first stage initially, in order to be able to inspect the correlation coefficients in the correlation matrix *R*. Since the purpose of this analysis is to link variables into factors, those variables must be related to one another and therefore have correlation coefficients larger than a Cronbach's alpha of .70 and factor loadings greater than .30. These numbers are consistent with the minimums needed in the social sciences for statistically significant correlations. Any variables that showed no substantial correlation with any of the others were removed from *R* in subsequent analysis. It is also advisable to check that the correlation matrix does not possess the highly undesirable properties of multicollinearity and singularity. The former is the condition in which the variables are very highly (although imperfectly) correlated; the latter arises when some of the variables are exact linear functions of others in the battery, as when the variable C is constructed by adding the subjects' scores on variables A and B. Should either multicollinearity or singularity

be present, it would be necessary to drop some of the variables from the analysis (Gray & Kinnear, 1998).

Rotation of Factors

Factor analysis is a variable reduction technique that simplification of data by combining numerous variables into a much smaller set of synthetic variables called "factors." Factor analysis is "designed to identify factors, or dimensions, that underlie the relations among a set of observed variables" (Pedhazur & Schmelkin, 1991, p. 66). As Tinsley and Tinsley (1987) noted:

> Factor analysis is an analytic technique that permits the reduction of a large number of interrelated variables to a smaller number of latent or hidden dimensions. The goal of factor analysis is to achieve parsimony by using the smallest number of explanatory concepts to explain the maximum amount of common variance in a correlation matrix. (p. 414)

The ability of factor analysis to detect underlying factors makes it an extremely useful tool for researchers who want to demonstrate that their results have construct validity.

Similarly, Gorsuch (1983) stated that "a prime use of factor analysis has been in the development of both the operational constructs for an area and the operational representatives for the theoretical constructs" (p. 350).

Thurstone's goal in developing his set of guidelines for rotating factors was that "the factor pattern of any given variable would be constant when the variable was included in another factor analysis containing the same common factors" (Gorsuch, 1983, p. 177). This leads to findings that are more replicable across studies. As Gorsuch noted, "Thurstone showed that such rotation leads to a position being identified for each factor that would be independent of the number of variables defining it. Therefore, a simple structure factor should be relatively invariant across studies" (p. 177).

In the present study an oblique rotation was used with a Promax procedure, since it was the assumption of the researcher that the primary factors might be related. The generalizability and replication of this research were better served with an oblique rotation.

Validity in Factor Analysis

Validity is the strength of conclusions, inferences, or propositions. More formally, Cook and Campbell (1979) defined it as the "best available approximation to the truth or falsity of a given inference, proposition or conclusion" (p. 93). In short, "Were we right?"

Validity can be established in a number of ways. The determination of the most appropriate way depends on the kind of measure. Face validity is usually not enough. If the variable is meant to assess mastery of subject matter, a test of content validity is valuable. Usually, a panel of experts agree that all important content areas have been covered. Construct validity can be determined by an appraisal of the correlation of the test with other measures of the same trait or ability. Factorial validity confirms the test with other measures of the same trait or ability. Factorial validity confirms the construct by showing the strong presence of expected factors in the tests. Criterion-related validity demonstrates that the test measure correlates highly with the concurrent validity or predicts future performance (predictive validity). Study validity refers to the validity of the measure, experiment, and people for the specific designated purpose. No test has omnibus validity; that is, no one test does it all (Metzloff, 1998).

Professionals have consistently distinguished between actual validity and face validity. Anastasi (1988) began a section on face validity as follows:

> Content validity should not be confused with face validity. The latter is not validity in the technical sense; it refers, not to what the test actually measures, but to what it appears superficially to measure. Face validity pertains to whether the test "looks valid" to the examinees who take it, the administrative personnel who decide on its use, and other technically untrained observers. (p. 144)

In the present study, content validity, construct validity, and factorial validity were considered to be important and tests of these forms of validity were applied. The survey was given to a panel of experts to review the content and constructs, the wording of the questions, and the extent to which the constructs accurately reflect the variables to be measured in the study. Feedback from both groups was incorporated into the final survey format. Tests of the factorial validity were done, once the data were collected and correlated for various factors.

Reliability in Factor Analysis

Reliability is the consistency of the measurement, or the degree to which the instrument measures the same way each time it is used under the same conditions with the same subjects. In short, it is the consistent repeatability of the measure. A measure is considered reliable if a person's scores on the same test, given twice, are similar. It is important to remember that reliability is not measured; it is estimated. Reliability is usually estimated in one of two ways: test/retest or internal consistency. For this study, the RVTS will be administered only one time, and internal consistency will be used to estimate reliability.

Internal Consistency

Internal consistency estimates reliability by grouping questions in a questionnaire that measure the same concept. In the present study two groups of 10 questions each measured the same concept (e.g., training in relationship violence). This permitted a

measurement of correlation between responses to those two groups of 10 questions to determine whether the instrument was reliably measuring that concept.

This study applied the common way of computing correlation values among the questions on the instrument: calculation of Cronbach's Alpha (Cronbach, 1951). Cronbach's alpha splits all questions on the instrument in every possible way and computes correlation values for all such combinations. The computerized statistical analysis software generates one number for Cronbach's alpha; as with a correlation coefficient, the closer this alpha to 1, the higher the reliability estimate of the instrument. Cronbach's alpha is a less conservative estimate of reliability than test/retest. The primary difference between test/retest and internal consistency estimates of reliability is that test/retest involves two administrations of the measurement instrument, whereas the internal consistency method involves only one administration of that instrument.

MFT Training Programs

Due to the nature of this research topic, it may be important to look at the status of graduate-level training being offered by counselor training programs in prevention and treatment of family violence. This was done to answer the following questions: Is the curriculum using the current factors that are highlighted in the literature and incorporating assessment for risk factors? What are the current assessments tools in family violence prevention and treatment? Is imminent danger being assessed and are safety plans being employed for victims at risk? Is administration of these instruments being taught in counselor preparation programs; if so, are the assessment instruments for violence used with each case that the marriage and family therapy graduate sees?

Rating of the graduate training program themselves will help in a correlation of marriage and family therapy graduates, licensed practitioners, faculty, and the training

program. Using this lens, this study may be viewed as a system within a system, when thinking of relationship violence treatment and prevention. The training and assessment of marriage and family therapy graduates in relationship violence takes place on multiple levels and in multiple contexts. It is intended in this study that the use of the RVTS survey will bring clinical awareness of the current training and assessment issues that are cited by experts in relationship violence in marriage and family therapy today.

Conclusions

It is important to remember that factor analysis is a relative procedure. There are no hard and fast guidelines for its application. Factor analysis assumes a linear relationship between variables (Guertin & Bailey, 1970); any other relationship would be inaccurately represented by a factor analytic structure.

This study should have a number of noteworthy strengths. First, the data were obtained from a national sample of marriage and family therapists, supervisors, and faculty members. The factors are generalizable to marriage and family therapy training programs and their content related to relationship violence assessment and treatment. Despite its limitations, this study underscores the importance of measuring and including training indicators within relationship violence coursework, treatment, and supervision.

At the state and local levels, prevention researchers and preventive intervention staff can promote the need for, and the empirically supported success of, early preventive interventions. Research findings indicating the effectiveness of preventive interventions might become part of the state and local policy agendas, leading to more proactive, constructive efforts to carefully and systematically implement proven prevention programs. Prevention interventions could be provided in early childhood and at key developmental transitions, using developmentally appropriate interventions.

It would be worthwhile to examine factors in the training process and in the host systems (e.g., schools, community agencies) that affect dissemination. This is a central focus for the next generation of prevention research. There is a critical need to understand and identify the key factors within communities and agencies that can lead to more or less acceptance of a new intervention. Often, the level of support for the program may affect agency acceptance by key administrative staff and by the staff's ability to critically review the program before its acceptance. Elements of the training process also may have profound effects on the effectiveness of the implementation of the program. Research is needed to examine these processes and factors with the same degree of scientific rigor as is apparent in clinical trial research (Lochman, 2000).

The origins of family therapy, its clinical techniques, and its training and supervision are mostly theory based. However, as the health care context changes, practitioners are confronted with increasing demands to provide evidence for the effectiveness of their practice (AAMFT, 2000). This includes how students are prepared for the field and how inservice training keeps supervisors and faculty members updated. This may also include a different way of measuring outcomes of graduate training programs.

CHAPTER 4
RESULTS

A survey design provides a quantitative or numeric description of some fraction of the population through the data collection process of asking questions of people (Fowler, 1988). This research implemented a cross-sectional online Web-based data collection method. Data were collected by means of a questionnaire containing 30 items, the majority of which were scored on a Likert-type scale from *very poor* to *excellent* on items 1-10 and *least important* to *very important* on items 11-20. Other questions asked for factual information and demographics, such as age, gender, and years of training. The variables were identified and are listed in Table 1 (chapter 3). All information used in this analysis was derived from the questionnaire data. This questionnaire was developed by the researcher and pilot tested for construct validity by a panel of experts in the field. The advantages of this survey design included the economy of the design, the rapid turnaround in data collection, the competency to get a national sample, and the ability to identify attributes of a population from a small group of individuals.

Participants and Demographic Description

A random sampling of 1,000 potential participants was randomly taken from lists obtained from the AAMFT clinical membership, AAMFT Approved Supervisor membership, and COAMFT Approved Graduate School and Faculty membership (AAMFT, 2003b). These 1,000 persons were sent an initial invitation to participate in the research by completing the RVTS survey. A total of 197 clinical members of the AAMFT responded by rating the 20 items on the RVTS survey questionnaire (appendix

A) regarding the degree of importance of the MFT training that they had received in the identification, assessment, and treatment of relationship violence. A representative sample of 1,000 potential participants realized 197 respondents (response rate 19.7%). As shown in Table 2, 102 respondents (51.8%) were female and 92 (46.7%) were male, with 3 (1.5%) missing data. The mean age of the respondents was 51.28 years, with a standard deviation of 10.81 years and a range from 22 years to 81 years, with 55 years and 53 years being the most frequently reported (13 respondents each). These data correspond closely to the 2004 survey cited by Lee, Nichols, Nichols, and Odom in their article "Trends in Family Therapy Supervision: The Past 25 Years and Into the Future." Using a similar population, they reported a mean age of 54 years (RVTS mean 51 years) and 55% females (RVTS mean 52%).

Table 2

Characteristics of Respondents ($N = 197$)

Characteristic and category	*n*	%	Mean	*SD*	Range
Gender					
Female	103	51.8			
Male	92	47.4			
Age (years)			51.28	10.81	22-81
Years as supervisors					
Therapists ($n = 122$)			5.59	7.77	
Supervisors ($n = 15$)			7.53	4.93	
Faculty ($n = 51$)			12.55	7.62	
Years licensed					
Therapists ($n = 121$)			13.68	9.74	
Supervisors ($n = 15$)			12.80	7.25	
Faculty ($n = 48$)			15.04	9.59	

The sample consisted of 51 MFT Faculty respondents, 15 supervisors, and 122 clinical members. Faculty had a mean of 15.04 years as a licensed therapist and 12.55 years as a supervisor, Supervisors had a mean of 12.80 years as a licensed therapist and 7.53 years as a supervisor, and Clinical Members had a mean of 13.68 years as a licensed therapist and 5.59 years as a supervisor. Faculty had the most years as supervisors.

Regarding their nationality, 181 (91.9%) responses came from the United States, 1 from Taiwan, 1 from Germany, 1 from Japan, 2 from Canada, 1 from Italy, 1 from Dominica, 1 from Holland, 1 from France, 1 from Peru, and 1 from Africa; 5 respondents did not identify their ethnic nationality.

The RVTS rating scale ranged from 1 = *very poor* to 6 = *excellent* for items 1-10 and from 1= *least important* to 6 = *most important* for items 11-20. In addition, the respondents answered 10 demographic items. The mean ratings (excluding item 10, which was omitted from analysis) ranged from 2.96 to 5.83. The mean ratings for the 20 self-rated items, based upon the 171 respondents who rated all of them, are reported in appendix G. The standard deviations of the responses for descriptive statistics ranged from 0.461 to 1.477 and are reported in appendix G.

Principal Axis Factoring and Oblique Rotation

This study used a standard computer software program for the factor analysis. To remove error variance, the study utilized a Principal Axis Factoring method of initial factoring. The correlation matrix was then decomposed and a principal axis factor analysis with iterated commonalties led to a least-squares solution of initial factoring. Considering that the factors were probably related, the oblique rotation was also used. Through this operation, a simple structure is sought; factors are rotated without imposing

the orthogonality condition and resulting factors are, in general, correlated with each other.

For the principal axes solution based upon $N = 171$, the latent roots (eigenvalues), differences in eigenvalues, and cumulative variance for which successive axes accounted are presented in Table 3. These were the values that were examined to determine the number of factors to carry into the initial rotations. In factor analyses, the eigenvalues generally fall off rapidly at first because systematic common variance is being extracted. The roots start decreasing almost linearly as mostly error variance is being extracted.

Table 3

Eigenvalues and Total Variance Explained

	Extraction Sum of Square Loadings			
Factor	Initial total	% variance	Cumulative variance	Total
1	5.413	28.491	28.491	5.008
2	3.577	18.829	47.320	3.252
3	2.231	11.743	59.063	1.855
4	1.255	6.608	65.671	
5	.994	5.232	70.903	
6	.832	4.380	75.283	
7	.659	3.471	78.754	
8	.648	3.410	82.163	
9	.542	2.854	85.017	
10	.491	2.582	87.599	
11	.457	2.407	90.006	
12	.436	2.295	92.300	
13	.396	2.085	94.386	
14	.276	1.454	95.840	
15	.259	1.363	97.202	
16	.229	1.204	98.406	
17	.160	.843	99.249	
18	.080	.422	99.671	
19	.063	.329	100.000	

Extraction Method: Principal Axis Factoring

The rule of thumb for the scree test criterion for determining the number of significant factors to retain is based on the graph of the roots (eigenvalues), claimed to be appropriate in handling disturbances due to minor (unarticulated) factors (Kim & Mueller, 1978). In this study the factors were extracted by using the formula "1 minus the elbow." In this study, the elbow was at 4 factors, so 4 - 1 = 3 factors. The Cattell scree test (Figure 1) plots the components as the x axis and the corresponding eigenvalues as the y axis. Moving to the right, toward later components, the eigenvalues drop. When the drop ceases and the curve makes an elbow toward less steep decline, Cattell's scree test indicates to drop all further components after the one starting the elbow. The elbow is somewhat subjective, but in this study the researcher decided that only the first three factors were worth retaining in the analysis (Cattell, 1994).

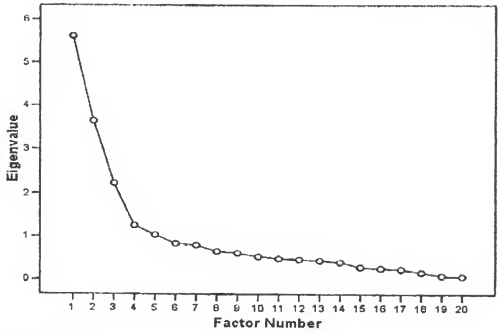

Figure 1. Scree plot

Factor Analysis Results

The principal axes factor extraction method was applied to the correlation matrix and the factor loadings with a Promax solution with Kaiser Normalization (Table 4). Only the factor loadings with a response greater than .40 were included in the factor analysis.

Table 4

Factor Loading Matrix: Rotated Factor Loadings of .40 or Greater in the Principal Axis Factoring, Based Upon N = *171*

Item	1	2	3
Recognizing signs and symptoms/cycle of violence	.749		
Identifying risk factors in relationship violence	.738		
Performing protection assessments rating	.737		
Identifying/assessing imminent danger	.650		
Recognizing batterer typologies	.629		
Self-knowledge in assessment skills	.603		
Assessing ethical standards	.542		
Recommending risk assessment/instruments	.480		
Identifying client resources	.436		
Assessing through a multicultural model	.431		
Intake/assessment of RV		.957	
MFT graduate training that I attended		.949	
Treatment approaches		.932	
MFT graduate training programs overall		.918	
Assessment and treatment in relationship violence			.962
Relationship violence skills today versus 5 years ago			.749
Screening for relationship violence in premarital counseling			.717
Working with gay/lesbian clients in relationship violence			.599
Obtaining restraining orders			.578

Note. Extraction method: principal axis factoring; rotation method: Promax w/Kaiser Normalization.

The most evident feature of the data represented in Table 4 was that there was a relatively stable three-factor structure. Factor 1 loadings ranged from .749 to .431, Factor 2 loadings ranged from .957 to .918, and Factor 3 loadings ranged from .962 to .578. Factors loading greater than .40 are presented in Table 4. Factor loadings of less than .40 were considered insignificant for this study due to low alpha score and hence were not included in the table.

Since the initial and extracted commonalties of item 10 were the lowest in the study (.240 and .215, respectively), they were eliminated from consideration in this study. According to Guertin and Bailey (1970), "The factors are best located when the produced extraction is as simple as possible" (p. 98). The three general criteria for simple structure are: (a) Factors should have the largest possible number of loadings approaching zero, (b) the variables should have the largest possible number of loadings on the factors approaching zero, and (c) every pair of factors should have the largest possible number of loadings approaching zero on one factor but not on the other (p. 99).

Identification and Naming of Factors

The items for the final version were selected with several criteria in mind. First, items were selected based on high factor loading with the three factors identified in the RVTS survey results. Second, items were selected to reduce redundancy and not overweight any single content area. Third, items were limited to keep the RVTS as brief as possible. Once this was decided, labels were given to the factors.

Factor 1 (including items 11-20) was named the importance of competencies and skills in the identification, assessment, and treatment of relationship violence. Factor 2 (including items 6-9 and excluding item 10) was named a self-rating scale of respondents' graduate training in the identification, assessment, and treatment of relationship

violence. Factor 3 (including items 1-5) was named a self-rating scale of respondents' knowledge in the identification, assessment, and treatment of relationship violence.

Reliability and Validity

The RVTS was administered once, and internal consistency was used to estimate reliability. Content validity, construct validity, and factorial validity were considered to be important for this study, and tests of these forms of validity were applied. The survey was given to a panel of experts to review content and constructs, wording of the questions, and extent to which the constructs accurately reflect the variables to be measured in the study. Feedback from both groups was incorporated into the final survey format.

Once the data were collected and correlated for various factors, tests of the factorial validity were done. The study applied the common way of computing correlation values among the questions on the instrument: calculation of Cronbach's alpha (Cronbach, 1951). The computerized statistical analysis software generates one number for Cronbach's alpha; as with a correlation coefficient, the closer this alpha to 1, the higher the reliability estimate of the instrument.

Factor 1

The sample size summary for Factor 1 is presented in Table 5. Calculation of Cronbach's alpha for Factors 1, 2, and 3 are shown in Table 6. Cronbach's alpha for Factor 1 was .814 for the 10 items. The item statistics for Factor 1 (mean score and standard deviation) are presented in Table 7 for the 184 persons who responded to all 10 items. Listed under summary item statistics (Table 8) are the item means, the item variances, and the inter-item correlation for the 10 items. The item-total statistics are reported in Table 9 and the scale statistics (mean, variance, and standard deviation) are presented in Table 10.

Table 5

Factor 1 (Items 11-20): Sample Size Processing Summary

Cases	*N*	%
Valid	184	93.4
Excluded[a]	13	6.6
Total	197	100.0

[a]Likewise deletion based on all variables in the procedure.

Table 6

Factors 1, 2, and 3: Reliability Statistics

Factor	Cronbach's alpha	*N* of items
1	.814	10
2	.967	4
3	.812	5

Factor 2

For Factor 2 (items 6-9, with item 10 omitted from analysis), Cronbach's alpha was .967 for the four items. Item statistics for Factor 2, giving the mean score and standard deviation, are presented for the 185 persons who responded to all four items. Also listed under summary item statistics are the item means, the item variances, and the inter-item correlation for the four items. The item-total statistics and the scale statistics are reported and the mean, variance, and standard deviated are presented (Tables 11 through 15).

Table 7

Factor 1: Item Statistics ($N = 184$)

Item[a]	Mean	*SD*
Assessing ethical standards	5.83	0.454
Identifying/assessing imminent danger	5.81	0.481
Performing protection assessments rating	5.74	0.530
Self-knowledge in assessment skills	5.72	0.557
Identifying client resources	5.66	0.623
Recognizing signs and symptoms/ cycle of violence	5.64	0.620
Identifying risk factors	5.58	0.639
Assessing through a multicultural model	5.46	0.874
Recognizing batterer typologies	5.05	1.088
Recommending risk assessment instruments	4.11	1.343

[a]Rating the importance of competencies and skills.

Table 8

Factor 1: Summary Item Statistics ($N = 10$)

Statistic	Mean	Min	Max	Range	Min	Variance
Item means	5.461	4.109	5.832	1.723	1.419	.277
Item variances	.596	.206	1.802	1.596	8.731	.268
Inter-item correlations	.372	.159	.638	.479	4.009	.016

Table 9

Factor 1: Item-Total Statistics

Item	SMID	SVID	CITC	SMC	CAID
Identify signs/symptoms	49.97	18.524	.628	.511	.786
Identify risk factors	49.03	17.972	.716	.579	.777
Protection orders	48.87	19.196	.599	.495	.792
Imminent dangers	48.80	19.681	.550	.573	.796
Identify batterer's typology	49.56	15.800	.610	.456	.785
Knowledge/skills	48.89	19.205	.562	.500	.794
Ethical standards (duty to warn)	48.78	20.076	.486	.314	.803
Use of risk assessments	50.50	15.902	.426	.268	.831
Identify client's strengths	48.95	19.538	.424	.260	.804
Use multicultural model	49.15	18.159	.448	.340	.803

Note. SMID = scale mean if item deleted, SVID = scale variance if item deleted, CITC = corrected item—total correlation, SMC = squared multiple correlation, CAID = Cronbach's alpha if item deleted

Table 10

Factor 1: Scale Statistics ($N = 10$)

Mean	Variance	*SD*
54.61	22.261	4.718

Table 11

Factor 2 (Items 6-9): Sample Size Summary

Cases	*N*	%
Valid	185	93.9
Excluded[a]	12	6.1
Total	197	100.0

[a]Likewise deletion based on all variables in the procedure.

Table 12

Factor 2: Item Statistics (*N* = 185)

Item[a]	Mean	*SD*
MFT graduate training programs overall	3.15	1.476
Treatment approaches	3.01	1.387
Intake/assessment of relationship violence	2.99	1.405
MFT graduate training that I attended	2.93	1.430

Note. MFT = Marriage and Family Therapist.

[a]Rating of Graduate Training.

Table 13

Factor 2: Summary Item Statistics ($N = 4$)

Statistic	Mean	Min	Max	Range	Min	Variance
Item means	3.020	2.930	3.146	.216	1.074	.008
Item variances	2.030	1.924	2.180	.256	1.133	.012
Inter-item correlations	.880	.842	.916	.075	1.089	.001

Table 14

Factor 2: Item-Total Statistics

Item	SMID	SVID	CITC	SMC	CAID
Intake/assessment of RV	9.09	16.895	.925	.875	.954
MFT graduate training that I attended	8.94	16.268	.933	.885	.952
Treatment approaches	9.07	17.196	.907	.849	.959
MFT graduate training programs overall	9.15	16.868	.906	.850	.960

Note. SMID = scale mean if item deleted, SVID = scale variance if item deleted, CITC = corrected item—total correlation, SMC = squared multiple correlation, CAID = Cronbach's alpha if item deleted

Table 15

Factor 2: Scale Statistics ($N = 4$)

Mean	Variance	*SD*
12.08	29.553	5.436

Factor 3

For Factor 3 (items 1-5), Cronbach's alpha was .812 for the five items. The item statistics for Factor 3 (mean score and standard deviation) are presented for the 192 persons who responded to all five items. Also listed are summary item statistics, item means, item variances, and inter-item correlation for the five items. The item-total statistics and the scale statistics are reported, as well as mean, variance, and standard deviated (Tables 16-20).

Table 16

Factor 3 (Items 1-5): Sample Size Summary

Cases	*N*	%
Valid	192	97.5
Excluded[a]	5	2.5
Total	197	100.0

[a]Likewise deletion based on all variables in the procedure.

Table 17

Factor 3: Item Statistics (*N* = 192)

Item[a]	Mean	*SD*
Assessment and treatment in relationship violence	4.92	0.909
Relationship violence skills today versus 5 years ago	4.92	0.932
Screening for relationship violence in premarital counseling	4.60	1.117
Working with gay/lesbian clients in relationship violence	4.25	1.206
Obtaining restraining orders	3.91	1.317

[a]Rating Knowledge and Skills in Relationship Violence

Table 18

Factor 3: Summary Item Statistics (N = 5)

Statistic	Mean	Min	Max	Range	Min	Variance
Item means	4.521	3.911	4.922	1.010	1.258	.193
Item variances	1.226	0.826	1.736	0.909	2.100	.150
Inter-item correlations	.492	.347	.648	.301	1.869	.011

Table 19

Factor 3: Item-Total Statistics

Item	SMID	SVID	CITC	SMC	CAID
Assessment and treatment in relationship violence	17.68	11.768	.788	.633	.732
Relationship violence skills today versus 5 years ago	17.68	12.459	.636	.447	.770
Screening for relationship violence in premarital counseling	18.01	11.639	.607	.425	.774
Working with gay/lesbian clients in relationship violence	18.35	11.455	.563	.356	.789
Obtaining restraining orders	18.69	11.334	.500	.284	.816

Note. SMID = scale mean if item deleted, SVID = scale variance if item deleted, CITC = corrected item—total correlation, SMC = squared multiple correlation, CAID = Cronbach's alpha if item deleted

The factor correlation matrix of coefficients for the intercorrelations of the three orthogonal extraction factors are presented in appendix H. The factors were rotated by an

Table 20

Factor 3: Scale Statistics ($N = 5$)

Mean	Variance	*SD*
22.60	17.507	4.184

Oblique Promax rotation method. These three sets of correlation coefficients were used in the factor analysis.

Summary of Reliability Statistics for Factors 1 to 3

Based upon the above reports of high internal consistency reliability for the three identified factors ($\alpha = .814$, .967, and .812, respectively), the RVTS survey was a reliable indicator of how well the different items measured the same issue. This is important because a group of items that purports to measure one variable should indeed be clearly focused on that variable, as seen in the factor loading matrix in Table 3, and supported again through the calculation of the Cronbach's alpha.

Summary

An exploratory factor analysis is used mainly as a means of exploring the underlying factor structure without prior specification of number of factors and their loading. The RVTS identified three factors from the results listed and controlled for some of the error by the measurement design of the exploratory factor analysis.

The RVTS was developed by defining the construct to be measured, designing the scale, generating an item pool, administering the scale, checking the data, measuring the coefficient alpha, and applying factor analysis. The response rate for the RVTS was 197

respondents (19.7%). Three factors were extracted from the factor analysis, resulting in Cronbach alphas of .814, .967, and .812.

The results of this exploratory study have provided support for three factors that are statistically related when evaluating relationship violence identification, assessment, and treatment. It has been shown that the information derived from these statistics was consistent within the competency for skills, assessment, and treatment domains. The factor structure of the RVTS indicates these three factors: Factor 1: Respondents' rating of the importance of clinical competencies associated with the identification, assessment, and treatment of relationship violence; Factor 2: Respondents' rating of their graduate training received in relationship violence; Factor 3: Respondents' self-rating of their knowledge and skills in the identification, assessment, and treatment of relationship violence.

Therefore, when evaluating MFT training in relationship violence, it is important to note that these factors would be related when considering curriculum development, continuing education training, licensure renewal coursework, initial licensure course work, MFT supervision training, accreditation standards, and policy improvements regarding relationship violence training on the graduate level. Ethical considerations, ethical standards, and codes must be adhered to when it comes to client safety and duty to warn. The ability to develop safety planning and to help clients to establish a restraining order injunction (ROI) would benefit clients who are in need of these services. MFTs must take the lead in this domain because they have the background training to make a significant difference in effective identification, assessment, and treatment of relationship violence.

CHAPTER 5
DISCUSSION

Evaluation and Discussion of the Results

This study investigated the current status of marriage and family therapists' graduate training in the identification, assessment, and treatment of relationship violence. Therefore, this study sought to address this issue through by attending to three research questions:

1. *How do MFTs rate themselves on their knowledge in the identification, assessment, and treatment of relationship violence?*
2. *How do MFTs rate their graduate training in the identification, assessment, and treatment of relationship violence?*
3. *How do MFTs rate the importance of specified competencies and skills in the identification, assessment, and treatment of relationship violence?*

The primary purpose of this study was to determine the factors most frequently reported by MFTs to be related to the identification, assessment, and treatment of violence. The statistical results show that the factor structure of the RVTS indicates three factors: Factor 1: Respondents' rating of the importance of clinical competencies associated with the identification, assessment, and treatment of relationship violence; Factor 2: Respondents' rating of their graduate training received in relationship violence; Factor 3: Respondents' self-rating of their knowledge and skills in the identification, assessment, and treatment of relationship violence. The populations sampled were licensed MFTs, approved MFT supervisors, and MFT faculty. This chapter includes

findings from the exploratory factor analyses, evaluations and discussion of results, ratings of importance, training methods, clinical assessments, limitations of the study, implications and recommendations for further research, and conclusions.

The RVTS, designed by the researcher, contained two subscales of 10 items each: (a) assessment of relationship violence, and (b) training/treatment issues in relationship violence; demographic data included age, ethnicity, gender, years of therapy experience, and years of supervisory experience. Experts in counselor education and relationship violence measured the content validity of this instrument. The RVTS was designed to measure whether graduate MFT programs prepare therapists in assessment and treatment of relationship violence. Program success was measured by survey responses regarding required coursework in relationship violence, endorsement of the program by counseling accreditation boards, and practitioners' self-reported self-efficacy in assessing and treating relationship violence. A representative sample of 1,000 potential participants realized 197 respondents (response rate 19.7%): clinical members of AAMFT, AAMFT Approved Supervisors, and faculty members in MFT training programs, recruited via nationwide random sampling. The framework to support these implications of the results and limitations of the study are discussed in this chapter.

Ratings of Importance

The findings for the first research question (items 1-5) correlated with Factor 3, respondents' self-rating of their knowledge and skills in the identification, assessment, and treatment of relationship violence. Factor 3 indicated a higher rating (4.92 on a 6-point Likert-type scale) for item 1, rating their skills to intervene adequately and competently in the identification, assessment, and treatment of relationship violence.

Item 4 received a rating of 4.92, rating their interventions skills in cases of relationship violence today as opposed to their skills 5 years earlier.

This is consistent with previous research that indicated that intervention and assessment skills in relationship violence were rated higher for those having graduated/become licensed within the past 5 years. The BBSE, an MFT regulating body in California, passed a bill in January 2004 mandating that a one-time continuing education units (CEU) course in assessment and treatment of intimate violence be taken within 6 months of licensure (BBSE, 2004). Item 5 received a lower rating, 4.60, rating their practice of screening for relationship violence in premarital counseling cases.

Item 2 received a lower rating, 4.25, rating their skills to intervene adequately and competently in cases of relationship violence within gay and lesbian client relationships. Item 3 received a lower rating, 3.91 (a little over midpoint on the scale), rating their knowledge regarding the acquisition of ROI. This would indicate a specific need for training and education in these items due to the low response regarding knowledge and skills in three areas: (a) the use of systematic risk assessments in order to recognize imminent danger and to formulate appropriate interventions related to safety, (b) intervening for violence within gay and lesbian client relationships, and (c) obtaining ROIs.

The mean years of experience among participating therapists was 13.6, among supervisors 12.8, and among faculty 15.0. The mean years of experience as supervisors among therapists was 5.59, among supervisors 7.53, and among faculty 12.55. Additional training, updates, and continuing education workshops would be needed for all three groups, since their experience was more than 5 years since graduating and, as a

group, they rated themselves lowest in this area. Inservice, updates, and additional education and assessment materials on screening in premarital counseling sessions would prove useful to improve the MFTs' knowledge and skills in the identification, assessment, and treatment of relationship violence, based upon these results. This would have an effect on the quality of the supervision of interns in this area and in the graduate training given by faculty members to MFT students.

The findings for the second research question (items 6-9) correlated with Factor 2, respondents' rating of their graduate training received in relationship violence. Factor 2 indicated a higher rating (3.15 on a 6-point Likert-type scale) for item 7, rating their MFT graduate training in relationship violence issues. Items on this subscale, questions 7, 9, 8, and 6, reported scores of 3.15, 3.01, 2.99, and 2.93, respectively. All of the responses were approximately 3 on this subscale. This indicates that additional graduate training is needed in relationship violence identification, assessment, and treatment.

The findings for the third research question (items 11-20) correlated with Factor 1, respondents' rating of the importance of clinical competencies associated with the identification, assessment, and treatment of relationship violence. Factor 1indicated a higher rating (5.81 on a 6-point Likert-type scale ranging from *not important* to *very important*) for item 12, the importance of assessing imminent danger in interpersonal relationships. This was a higher score on this subscale, indicating that it was very important to the MFTs responding to the study.

This was followed closely by item 13, with a score of 5.74, regarding the importance of performing assessments quickly and efficiently to provide immediate protection to the victim and/or children in the identification, assessment, and treatment of

relationship violence. Item 11 produced a score of 5.72, regarding the importance of having knowledge and skills in identification, assessment, and treatment of relationship violence. Item 19 produced a score of 5.58, regarding the importance of identification of risk factors for relationship violence in assessment of clients.

The rest of the scale also rated highly, from 5.66 to 5.01, the lower rated being item 20, which included the use of risk assessments rated at 4.11. The most interesting result from this research was the lower rating of 4.11 for item 20. This low rating of importance indicates an interesting juxtaposition in the results for this subscale. On the one hand, the MFTs indicated that it was very important to have the specific competencies and skills to identify, assess, and treat relationship violence; they also indicated that it was very important to assess quickly for imminent danger to get protection for the victims.

Training Methods

Previous research sets a precedent for this specific type of training. Riggs et al. (2000) discussed the need for identifying risk factors for domestic violence. They stated that the extent and potential danger of the problem of domestic violence warrant systematic screening and assessment in all mental health settings. However, the MFTs in this study also rated this as least important. They rated it very important in adhering to ethical standards, duty to warn, confidentiality, or helping the client obtaining an ROI or file an abuse report.

This would indicate a mixed feeling about the importance and understanding of relationship violence identification, assessment, and treatment. These results suggest that additional training in specific knowledge and skills in relationship violence should be provided, along with additional training and testing on ethical standards with regard to

the duty to warn, confidentiality, helping clients to obtain ROIs, identifying batterers' typologies and risk factors, and the use of risk assessments instruments.

A recent Johns Hopkins School of Nursing research report that also looked at the importance of mental health professionals to assess for potential risk factors for imminent danger included the *Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study*. This study, published in the July 2003 issue of the *American Journal of Public Health*, found that a combination of factors increased the likelihood that a woman would be murdered by her partner. Among the most important predictors were unemployment, access to guns, and threats to kill (Huson, 2003).

> Such information can be useful in preventing these killings. In the United States, women are killed by intimate partners more often than by any other type of perpetrator, with the majority of these murders involving prior physical abuse. Determining key risk factors, over and above a history of domestic violence, that contribute to the abuse that escalates to murder will help us identify and intervene with battered women who are most at risk. (p. 1)

According to Campbell, results of the study suggest that steps such as increasing shelter services for battered women, increasing employment opportunities, and restricting abusers' access to guns can potentially reduce rates of femicide. She said that health care professionals also play a critical role in identifying women at high risk.

J. Campbell (2003) recommended that, when treating women who have been abused, health care professionals ask questions such as, "Is your partner unemployed? Is he very controlling of your behavior all the time? Has he threatened you before? Is there a stepchild in the home? Is there a gun in the home?"

> These are all relatively simple questions that can help assess the level of risk. In cases of extreme danger, such as a situation where the abuser is highly controlling and the woman is preparing to leave him, it is important for practitioners to warn the woman not to confront the partner with her decision and to alert her of the risk of homicide and the need for shelter. (p. 1097)

A review of the AAMFT ethical standards should also reflect these specific findings to educate and train their members with regard to identification, assessment, and treatment of relationship violence. These results are also consistent with research by Hansen et al. (1991), in which mental health practitioners did not value the importance of the ability to identify, assess, and intervene for imminent danger in cases of relationship violence. Forty-one percent of the therapists surveyed indicated no recognition of domestic violence. Interventions provided by therapists in this study were also negligent with regard to violence potential. For example, 55% of the respondents reported that they would not intervene even when the demonstrated violence required immediate action. Only 2% reported a potential for lethality in these cases. A scant 11% indicated that they would obtain protection for the wife by helping her to develop a safety plan, obtain shelter, or obtain an ROI. No risk assessment instruments were included in this research.

In a recent article in the *Journal of Marital and Family Therapy* by Lee, Nichols, Nichols, and Odom (2004) entitled "Trends in Family Therapy Supervision: The Past 25 Years and Into the Future" the authors discussed the title and role of MFT and its scope of practice that are regulated by law (see Sturkie & Bergen, 2001). They also stated that there are approximately 46,000 practicing MFTs in the United States, only 40% of whom are clinical members of the AAMFT (Northey, 2002) and therefore guided by that organization's standards.

Current COAMFTE standards also may be limiting the need for the AAMFT Approved Supervisor credential. Currently in the United States there are 55 master's degree programs, 20 doctoral programs, and 13 postgraduate institutes that are either accredited or candidates for accreditation (AAMFT, 2003a). COAMFTE still requires

accredited programs to have a minimum of three faculty members, only two of whom must be AAMFT-approved supervisors; the other can be an "equivalent." In the past the AAMFT requirement for supervision was rigorous, with an on-site supervision requirement. This has also changed for the supervision of students' clinical experience; an off-site supervisor is now acceptable and an "equivalent" supervisor may also be acceptable for doctoral internships.

Approved supervisors constitute 13% of the approximately 2,046 clinical members, with an increase in female supervisors from 22% to 55% since 1976 (Lee et al., 2004). Clinical supervisors are an important part of the training for those 35% currently seeking credentials as MFTs whose formal educations are in disciplines other than MFT (Lee, 2002). This study reviewed the current demographics of MFTs who responded to the RVTS survey. In the RVTS survey 13% of the 1,000 clinical members also self-identified as supervisors. They reported an average 12.8 years of licensure as supervisors and 7.53 years of experience as supervisors. Similar results were noted that various disciplines are now establishing themselves as MFTs with little or no specific training in MFT or little or no supervision by an AAMFT-approved supervisor. There were also changes noted on a programmatic level from MFT graduate programs primarily being COAMFTE accredited to various other accreditation boards approving MFT curricula and programs at the graduate level.

Clinical Assessments

Validity for violence assessments is greatly improved when they include both a written questionnaire and a clinical interview conducted in private with individual clients (Aldarondo, 1998). There have been many contradictory studies on the validity of assessments from both perpetrators and female victims. Pence (1996) and Bograd and

Mederos (1999) have argued that clinical assessments should give more weight to reports by women victims than to those by their male partners. Conversely, knowledge that female victims sometimes block self-awareness about severe violence led J. C. Campbell (1995) to argue that female victims are not always the best predictors of whether they are at risk. Wiesz, Tolman, and Saunders (2000) investigated this apparent contraindication, using data collected from women during exit interviews in a domestic violence shelter. These researchers found that only 4% of the women failed to predict accurately whether they would become victims of an attack in the 4 months following the exit interview. The researchers suggested that women's predictions should be given considerable weight in abuse assessments, particularly when a women believes that she is in imminent danger of an attack (Jory,2004).

MFTs have ethical and legal obligations to effectively evaluate and intervene to protect victims of psychological or physical abuse (Jory, 2001). Bograd and Mederos (1999) called on MFTs to incorporate universal screening procedures for domestic violence and psychological abuse. Universal screening should include reasonable assessments about the frequency and severity of past abuse and predictions about the potential for future abuse. Screenings would help victims to take steps for self-protection, help perpetrators to establish relationships based on respect and accountability, and guide decisions on treatment modalities (Jory & Anderson, 2000). This study asked respondents to rate the importance of screening measures and assessing risk factors and to self-rate the training that they received in the assessment and treatment of relationship violence.

Limitations of the Study

This study was delimited to MFT practitioners, supervisors, and faculty members from a national sample. Different results might have been obtained if other mental health professionals had been sampled or if other training programs had been included in the sample. Although effort was made to assure that the findings of this study were reliable, limitations existed that should be considered when interpreting the results. In particular, limitations of the study are associated with the respondents, potential confounders, random error, the response rate, possible nonresponder bias, nonrandomized samples, and alternative explanations.

Respondents

A few study limitations should be noted. First, these results are based on cross-sectional data and do not provide a causal model. Second, relationship violence training indicators were assessed at one point in time, which could bias the estimated relationship violence training/assessment associations. The results may not take into account further training or mandated update training in relationship violence that may occur before or after formal graduate training. Longitudinal study designs that use more comprehensive measures of relationship violence training and curricula are needed to minimize bias that may result from measuring relationship violence in a "snapshot" manner.

Potential Confounders

A number of potential confounders (e.g., advanced training that occurs at institutes outside of formal graduate school curricula, advanced consultation on relationship violence, attendance at mandatory update training sessions on relationship violence) were not assessed accurately. Item 10 was apparently not clear to respondents and was dropped because it had too many confounding responses: Some respondents answered in

number of hours, others in number of courses, others in number of CEU credits. Inclusion of the correlates that were intended to be measured by Item 10 might have modified the findings related to the associations observed in this study.

Random Error

Random error is the unpredictable error that occurs in all research. It may be caused by many different factors but it is affected primarily by sampling techniques. Some of the random error in this study occurred (a) due to error messages of addresses that were no longer valid, and (b) because some intended respondents were not able to send their responses due to browser incompatibility.

A few respondents apparently had difficulty with the way in which a given question was worded or the tone that they inferred from the question, and they declined to answer that question. Missing data were automatically coded with listwise deletion, and all responses from that respondent were eliminated from that statistical computation. The researcher attempted to control for this possibility by extensive effort and consultation in question design and subsequent revisions of items and scales. These efforts served to reduce the extent of error in the final analysis and yielded high reliability and validity for this instrument.

Selecting the Web-based design for this study required extensive time and effort and presented many problems. Numerous consultations from those who had conducted electronic studies provided sound advice but also included accounts of various problems and glitches with operating systems. The eventual choice was the program SurveyWiz©, which was specifically designed to receive data in the behavioral sciences. SurveyWiz was developed by Dr. Birnbaum of California State University, Fullerton, who gave

permission to use the application in this study. The program was developed to work with many operating and Internet browser systems, and was described as quick and easy to use, confidential, and easily convertible to SPSS files. While the program is well designed, the researcher met with numerous problems in applying it for this study.

Some glitches were identified in a pilot study, in which the survey was administered to a pilot group in order to provide construct validity for the instrument. The server Stetson University did not forward results to the data collection site. It was necessary to enter to the server to change the program software ACTION and redo this information. After this was successful, the next glitch appeared as incompatibility in the various browsers that would receive the invitations to participate in the study. For example, the instrument could be used in Mozilla (the browser for which SurveyWiz was developed) but crashed in Explorer© and Netscape® browsers. This was a major problem. The Stetson CIT department solved that problem so that the survey easy to read and the respondent could complete it easily. Then, some respondents received the survey in the html version because their browser did not support the other version. Once this problem was fixed, the survey was easily accessible and the data were routed to the collection site properly. Responses were saved in an SPSS™ format and converted for factor analysis. This part of the research required extensive computer programming consultation. However, building the Web page and using the survey instrument on the Internet proved to be a valuable learning experience for the researcher and provided tools that can be used to teach the process in the future.

Response Rate

The low response rate associated with the sampling procedures in this study also places limitations on the interpretations of the findings. Even though a good distribution based on personal and professional characteristics existed among the respondents that closely equated to the same demographics of the AAMFT professional organization, the initial response rate of 19.7% was low.

Possible Nonrespondent Bias

Findings from most studies cannot be generalized outside of the sample population due to the difficulty of nonrespondent bias from culturally diverse, lower-socioeconomic groups and the gay/lesbian population. These groups can have low respondent rates and are generally undersampled.

Thus, when therapists work multiculturally, they must be aware of the importance of both ethnic knowledge and cultural information elicited in conversations with clients. Although specific practices for multicultural counseling vary among therapists, practitioners in the field share common assumptions. These include exploring clients' world views, considering the role of acculturation, and taking on additional roles. This study included an automatic coding response form that recorded the respondents' demographic data, including culture/nationality, gender, age, and level of training. Included in the coded response were the dates of response and the respondents' email locations. This information was used in follow-up notices and to prevent a participant from responding more than once.

Nonrandomized Samples

Many sample populations are convenience samples, usually taken at a clinic, school or university. They are not usually randomly generated. In these cases there is not

enough use of regression analysis to control for confounding variables. Very few studies on family violence have large sample sizes; they do not report effect size, confidence intervals, or significance tests (Cohen, 1994). In this study a systematic random sample was used to survey 1,000 family therapists, family therapy supervisors, and family therapy faculty members.

Alternative Explanations

Other alternative findings and speculations from these data could suggest that the results were not very surprising and that the three factors closely matched the initial research questions. It is very difficult to eliminate errors in questionnaire construction. The results fell neatly in place, which may be a result of respondent bias (wanting to rate themselves well in certain areas). The respondents' belief systems may have affected the way in which they answered the questions. Readers should include these alternative findings in the way in which they view the data. They should also consider the findings as a way to change their thinking about how they conduct assessment questions for relationship violence. Interventions for relationship violence based on previous training assumptions may be challenged. This research can also bring additional benefit such as improved knowledge in the awareness of critical issues in domestic violence for clinicians, faculty, and supervisors. Potential implications for applied work and clinical applications could involve the delivery method of training on domestic violence. Inservice training, graduate seminars, continuing education units, graduate coursework, and domestic violence supervision models are all viable methods of providing specific training competencies to improve MFT deficits in this area.

Respondent bias related to the importance that is placed on learning more as part of professional development may have contributed to some of the results. Research in the area of relationship violence training advances with improvements in design and measurement. In this study a Web-based exploratory factor analysis was used to gain the results quickly and reliably. This design could be stronger if a follow-up confirmatory factor analysis were completed with a different sample from the same population to yield more conclusive results.

Implications and Recommendations for Further Research

This section presents the implications of the findings of this study for the current status of MFT graduate training in the identification, assessment, and treatment of relationship violence. Based on the lack of studies investigating MFT graduate training factors in relationship violence, the results of this study can serve as baseline data for further research. The results indicate that some factors are more important to MFTs than others. The findings also have important implications for MFT therapist educators. For example, MFT therapist educators could review the findings of the study with regard to the curriculum components that they include in family violence coursework and other clinical assessment coursework that they teach and/or offer in their programs.

Findings from this research suggest alternative training technologies that may be more useful and relevant applications for training in relationship violence. Alternative training could make use of technology such as online CEU training in specific areas of need. It could also include training manuals with appropriate assessment and resource information for working with imminent danger, including safety plans, assessing risks, working with gay and lesbian violence, and obtaining ROIs. The advantage of using relevant information would be to improve the knowledge base and competence skills of

MFTs in working with relationship violence cases. It would also benefit faculty and supervisors in providing their trainees with relevant materials that would provide direct impact on their domestic violence competency and skill level.

The RVTS provides a single measure by which results of studies in this area can be compared. The development of the RVTS is a valuable contribution to research on assessment, treatment, and training issues in relationship violence at the graduate level. Further research is needed to replicate the results of the current study, to do a confirmatory factor analysis with a different group from the same sample population, to extend the findings of this study to other groups, and to establish more extensive normative data for the RVTS.

Theoretical, Training, and Ethical Implications

Violence is escalating so quickly that professional counselor training is inadequate to meet the increased need. Bandura (1982) suggested three ways to enhance professional self-efficacy, in order of importance: (a) performance mastery, (b) vicarious experiences, and (c) verbal persuasion. If professional counselor preparation courses are not implementing adequate training for counselors to gain mastery or internship experience in the field of family violence, what are the profession's ethical obligations to change this for the better? Ethically, by the COAMFTE standards for practice, this competency is required to assess for imminent danger, to protect client safety, and to comply with duty to warn.

According to Lochman (2000), inadequate training and supervision of intervention providers is a barrier to effective dissemination. Training without ongoing supervision or consultation may not be sufficient for training staff in how to deal with expected and

unexpected problems in the delivery of a parent training program and counselor training programs. Better models of training can include up-front workshop training followed by regular consultation meetings at a prearranged rate (e.g., monthly, weekly) and specific in-service treatment based on empirical research findings. Other alternative training opportunities could provide for immediate "crisis" consultation if significant difficulties develop in the delivery of services.

The need for both quantitative and qualitative research in this area is great; the need for approaches in counseling that address the needs of the sizeable population of children and adults affected by maltreatment is critical. Qualitative methodology offers a means for exploring the contextual nature and dynamics in a population of women with a shared experience. Follow-up research involving interviews from some of the quantitative findings could be used to measure intergenerational perspectives (Armsworth & Stronck, 1999).

As the system of health care delivery evolves, it is certain that practitioners will be asked to demonstrate that the services that they provide are indeed effective for the clients whom they serve. Perhaps a more important concern is that practitioners have an ethical obligation to offer clients the best services possible, given the present state of knowledge regarding program and treatment effectiveness.

From the data gathered via the RVTS instrument, a quantitative report was produced from the exploratory factor analysis. A qualitative method could easily be added to a confirmatory factor analysis in future research. This qualitative approach could provide additional contextual data and give broader insight for interventions and applications of treatments for relationship violence issues.

Conclusion

Recent attention to the problem of relationship violence requires MFTs and other multidisciplinary professionals to identify appropriate policy and practice responses. The statistical results show that the factor structure of the RVTS indicates three factors: Factor 1: Respondents' rating of the importance of clinical competencies associated with the identification, assessment, and treatment of relationship violence; Factor 2: Respondents' rating of their graduate training received in relationship violence; Factor 3: Respondents' self-rating of their knowledge and skills in the identification, assessment, and treatment of relationship violence.

Broader policy implications from the results from the first factor, clinical competencies in the identification, assessment, and treatment of relationship violence, indicate a correlational relationship between the importance of current practitioners to recognize imminent danger and the importance to formulate appropriate interventions related to safety and assessment skills. Findings from the second factor, graduate training received, indicate a correlational relationship between graduate training and improved quality and longer duration of graduate training in relationship violence. Findings from the third factor, self-rating of knowledge and skill in relationship violence, indicate a correlational relationship between ethical training requirements and licensing and accreditation standards.

As a result of this study, alternative educational methods, such as inservice training with specific curriculum, may be recommended. It may be necessary to adjust teaching styles/delivery methods to include this study's implications for ethical boards such as COAMFT/AAMFT. This is expected to improve the knowledge of MFTs in the treatment of relationship violence and to provide useful and relevant applications. This

type of training can also bring additional benefits such as updating MFTs who received their initial training over 5 years prior and helping to provide better services to the diverse client populations that they serve.

To summarize, this exploratory factor analysis indicated specific problems in the ability of current practitioners on a national level to (a) use systematic risk assessments in order to recognize imminent danger and to formulate appropriate interventions related to safety, (b) intervene for violence within gay and lesbian client relationships, and (c) obtain ROIs. The need for improved quality and longer duration of graduate training in relationship violence and the need for more stringent training requirements by licensing and accreditation boards are supported.

These results suggest that additional training in specific knowledge and skills in relationship violence be offered, along with additional training and testing on ethical standards with regard to the duty to warn, confidentiality, and helping clients to obtain ROIs or file an abuse report. A review of the AAMFT ethical standards should also reflect these specific findings to educate and train members with regard to identification, assessment, and treatment of relationship violence.

As relationship violence continues to increase in the current political and social spheres, therapists, supervisors, and faculty members must assign priority to which types of intervention and assessments are currently working in the field. Practitioners, supervisors, and faculty members must be well trained in these emerging areas. They must show that existing programs are effective and efficient in meeting their clients' and students' goals in the assessment and treatment of relationship violence.

While providing some quantitative and empirical results regarding relationship violence training and treatment, it is intended that this paper contribute to policy implications on a national level, such as (a) proactive policy formulation, that is, policies more oriented to promoting specific assessment, treatment, and training activities among MFT graduate training institutions and their students; (b) finding alternative ways to train and update MFTs through creative training methods, such as a graduate seminar on issues that do not fit into the general curriculum or specific continuing education coursework in relationship violence so students can gain the competencies needed to treat relationship violence effectively; and (c) increased collaboration between training institutions and licensing boards to this end. Together, these improved conditions would enhance and intensify the local treatment service capabilities and innovative competence of MFTs in relationship violence treatment as a whole. Further research is needed to confirm the results of the current study and to extend the findings of this study to other groups.

Findings from research lead to better understanding of relationship violence and call for progress in the design and assessment of policy to improve an area of ethical obligation in assessing imminent danger in cases of relationship violence. The advantage of this would be the improved health, safety, and welfare of clients and the profession.

APPENDIX A
RELATIONSHIP VIOLENCE TRAINING SURVEY
(WEB VERSION)

Instructions for Relationship Violence Training Survey

Relationship Violence Training Survey (RVTS)

Contact: Principal Investigator:

Marie T. Bracciale, LMFT, LMFCC, CAP

AAMFT Approved Supervisor
Doctoral Candidate
Counselor Education Program
Department of Counselor Education
1215 Norman Hall
University of Florida
Gainesville, Florida
(386) 574-8155
mariebuf1@aol.com

Faculty Advisor:

Dr. Silvia Echevarria-Doan, Ph.D.
silvia@coe.ufl.edu
(352) 392-0731
Fax: (352) 846-2697
UFIRB Office:
P.O. Box 12250
University of Florida
Gainesville, Florida
32611-2250

Title: The Current Status of Marriage and Family Therapists' in the Identification, Assessment and Treatment of Relationship Violence.

Informed Consent Information

Purpose of Research: The primary purpose of this study is to determine the factors most frequently reported by MFTs to be related to the identification, assessment and treatment of violence via (a) a self-rating scale of their knowledge in the identification, assessment, and treatment of relationship violence, (b) a self-rating scale of their graduate training in the identification, assessment, and treatment of relationship violence and (c) how they rate the importance of competencies and skills in the identification, assessment, and treatment of relationship violence. Other types of questions will also be asked regarding demographics items such as: personal information, sexual preference, years of education and years of experience you have as a licensed counselor.

Assurance of Confidentiality: In order to assure your frank and forthright participation, the information that you will be providing in this survey will be kept confidential. Individual data will not be shared with your co-workers, supervisors, managers, or other administrators. The data will be summarized, and a summary will be provided to those who are interested, but this summary will not include any information that could be linked back to you directly. Your identity will be kept confidential to the extent provided by law.

Procedures to be Used / Voluntary Nature of Participation: After reading the passive consent form, you will be taken to the questionnaire page. This is a Web-based survey design, with all data being entered into a secured server. This will take you approximately 15 minutes to complete. If you wish to drop out of the study, you may do so by leaving the Web-site before submitting the results, without any consequences. When you have completed the questionnaire, you may submit your responses by clicking on the "Finished" button at the end of the survey.

Risks to the Individual: The risks involved in your participation are minimal. There is a possibility that your responses could be viewed by an outside party if you do not EXIT (CLOSE) your Internet browser (e.g., Netscape Navigator, Internet Explorer) as soon as you finish responding to the questionnaire because your responses might be visible if you (or someone else) clicks the BACK arrow on the browser. In order to ELIMINATE this possibility, you should EXIT/CLOSE the browser as soon as you finish responding to the survey and have submitted your responses.

Benefit to the Individual: Your participation may help you think about some important aspect of relationship violence that would be important to include in teaching and supervising students. Your participation may also help you develop a more conscious understanding of intimate partner violence (IPV) and the current assessment and treatment factors.

Human Subject Statement: If you have any questions about this research project, contact the principal investigator, Marie T. Bracciale, LMFT, Doctoral Candidate at mariebufl@aol.com or Dr. Silvia Echevarria-Doan, Ph.D. Chairperson, at silvia@coe.ufl.edu. If there are concerns about the treatment of research contact UFIRB-Institutional Research Board at the University of Florida, P.O. Box 112250, Gainesville, Florida, 32611-2250 or http://irb.ufl.edu

Informed Consent: Below is a statement of informed consent, above you will find details regarding confidentiality, and how the study will be conducted. Please read it carefully. If you have questions regarding the study call the principal investigator, or send us an e-mail (phone number and e-mail listed). You do not have to answer any question you do not wish to answer. Once you have read the above and agree to the following consent form please click on the voluntary consent to participate link below.

I have had the opportunity to read the procedures described above, and ask questions about the right not to participate in this study. I agree to participate in the procedure and I have received a copy of this description. By clicking on the arrow below, completing the voluntary consent responses, I willing give my consent to participate in this study.

◉ I VOLUNTARILY GIVE MY CONSENT TO PARTICIPATE IN THIS STUDY
Yes ○

For the purpose of this research, Relationship Violence will be defined using the terms as defined by Florida Statute

741.28-741.31

"Relationship violence" means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit.

" Family or household member" means spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who have a child in common regardless of whether they have been married or have resided together at any time.

"Assessing Risk Factors" means warning signs and profiles to identify persons who may be "at risk" for a serious violent episode. Fundamental principles for conducting an assessment of violence potential in clinical contexts. The more contemporary conceptualization, dangerousness or "risk" as a construct is now predominantly viewed as contextual (highly dependent on situations and circumstances), dynamic (subject to change), and continuous (varying along a continuum of probability)(National Research Council, 1989).

"MFT Graduate Training" means any training you received while registered in a Marriage and Family Therapist Graduate Training Program in which you received your degree. Any consultation or supervision you received while in this training program would be included in your personal rating scale.

"MFT Graduates" for the purposes of this study would include: current and former Marriage and Family Therapy students enrolled in a Marriage and Family Therapy program.

Rating System: Based on your own experience, consultation, MFT graduate coursework or supervision.

In the RTVS survey constructed for this study a six-point rating scale is used. In the first section relating to Graduate Training in the Identification, Assessment and Treatment of Relationship Violence only labels VERY POOR and EXCELLENT will dictate the end points. In the second section on the Importance of Competencies in the Identification, Assessment and Treatment of Relationship Violence only labels NOT IMPORTANT and VERY IMPORTANT define the two end positions. All intermediate positions are unlabeled. You are asked to discriminate between the two end points to define the meaning of your response. Please rate the survey using any of the points between very poor and excellent.

Relationship Violence Training Survey (RVTS)

Rating System: Please rate yourself based on your own individual experience, consultation, MFT graduate coursework or supervision.

Title: The Current Status of Marriage and Family Therapists' in the Identification, Assessment and Treatment of Relationship Violence.

Please use your mouse to rate your answer

Rating my knowledge and skills:

◉ 1. How do I rate my skills to intervene adequately and competently in the identification, assessment and treatment of relationship violence?
very poor ○ ○ ○ ○ ○ ○ excellent

◉ 2. How do I rate my skills to intervene adequately and competently in cases of relationship violence within gay and lesbian client relationships?
very poor O O O O O O excellent

◉ 3. How do I rate my knowledge regarding the acquisition of Restraining Orders (ROI)?
very poor O O O O O O excellent

◉ 4. How do I rate my intervention skills in cases of relationship violence today, as opposed to my skills 5 years ago?
very poor O O O O O O excellent

◉ 5. How would I rate my practice of screening for relationship violence in Premarital counseling cases?
very poor O O O O O O excellent

Rating my graduate training:

◉ 6. How do I rate the MFT graduate training program that I attended in training students in relationship violence identification, assessment and treatment?
very poor O O O O O O excellent

◉ 7. How do I rate my MFT Graduate Training regarding relationship violence issues?
very poor O O O O O O excellent

◉ 8. How do I rate my MFT Graduate Training in training in relationship violence intake assessments in the identification, assessment and treatment of relationship violence?
very poor O O O O O O excellent

◉ 9. How do I rate my MFT Graduate Training in relationship violence treatment approaches in the identification, assessment and treatment of relationship violence?
very poor O O O O O O excellent

◉ 10. How do I rate the adequacy of Continuing Education (CEU) requirements in relationship violence for MFT Graduates? (Most states require a 2 hour CEU course for licensure renewal)
very poor O O O O O O excellent

Competencies in the Identification, Assessment and Treatment of Relationship Violence As Reported by MFT's

Please use your mouse to rate your answer

Importance of competencies and skills in identification, assessment, and treatment of relationship violence:

◉ 11. How important is it to have knowledge and skills in identification, assessment and treatment for relationship violence?
not important O O O O O O very important

◉ 12. How important is it to assess imminent danger in interpersonal relationships in identification, assessment and treatment for relationship violence?
not important O O O O O O very important

◉ 13. How important is it to perform assessments quickly and efficiently to provide immediate protection to the victim and/or his/her children in identification, assessment and treatment of relationship violence?
notimportant O O O O O O veryimportant

◉ 14. How important is it to recognize Batterer's Typologies in identification, assessment and treatment of relationship violence?
notimportant O O O O O O veryimportant

◉ 15. How important is it to identify a client's resources and strengths during the assessment session in identification, assessment and treatment of relationship violence?
notimportant O O O O O O veryimportant

◉ 16. How important is it to recognize the signs and symptoms of relationship violence and understand the cycle of violence/power in the identification, assessment and treatment of relationship violence?
notimportant O O O O O O veryimportant

◉ 17. How important is it to assess and adhere to ethical standards?(confidentiality, duty to warn, help client obtain a restraining order (ROI) or file an abuse report) in identification, assessment and treatment of relationship violence
notimportant O O O O O O veryimportant

◉ 18. How important is it to assess clients using a Multicultural Model? (Including looking at race, gender, oppression, poverty, violence, substance abuse, contextual and community issues) in identification, assessment and treatment of relationship violence?
notimportant O O O O O O veryimportant

◉ 19. How important is it to include identification of risk factors for relationship violence in the assessments of clients in identification, assessment and treatment of relationship violence?
notimportant O O O O O O veryimportant

◉ 20. How important is it to use risk assessment manuals/instruments (e.g. Seeking Safety by Lisa M. Najavits) in identification, assessment and treatment of relationship violence?
notimportant O O O O O O veryimportant

Demographics

◉ 21. Are you Male or Female?

O Female
O Male

22. What is your age? [ ] years.
23. How many years of Education have you completed?

Put 18 for Master's degree (M.A., M.S., MSW, etc.).
Put 20 for Doctorate degree (Ph.D., M.D., PsyD.,etc).
Education: [ ]

24. Nationality (country of birth): [ ]

25. Degree specialization:

Put 1 for marriage and family therapy
Put 2 for mental health counseling
Put 3 for counselor education
Put 4 for school counseling
Put 5 for clinical counseling
Put 6 for registered nurse
Put 7 for medical doctor
Put 8 for clergy
Put 9 for social worker
Put 10 for other

26. Number of years experience as a licensed marriage and family therapist:

27. Number of years of experience as a supervisor:

28. What is the number of supervision courses you have completed?

29. What is your marital status?

Put 1 for single/unmarried
Put 2 for married
Put 3 for domestic partners
Put 4 for divorced/not remarried
Put 5 for separated
Put 6 for widow
Put 7 for divorced/remarried

30. What is your primary sexual orientation?

Put 1 for bisexual
Put 2 for homosexual
Put 3 for heterosexual

31. Is this University, Training Program, Business or Agency that you work for approved by COAMFTE (Commission on Accredidation for Marriage and Family Therapy Education) Credentialing?

Put 1 for Yes
Put 2 for No
Put 3 for Unsure

32. Are there other credentialing bodies that have accredited your University, Training Program, Business or agency such as (e.g., CACREP, CSWE, COAMFTE, NLAC, APA)?

Put 1 for CACREP (Council for Accredidation of Counseling and Related EdcuationalPrograms)
Put 2 for CSWE (Council on Social Work Education)
Put 3 for COAMFTE (Commission on Accredidation for Marriage and Family Therapy Education)
Put 4 for NLNAC (National League for Nursing Accrediting Commission)
Put 5 for APA (American Psychological Association, Committee on Accredidation)
Put 6 for other
Put 7 for Unsure
List numbers seperated by comma if more than one accrediation

33. Please list your email address:

34. Which profession do you spend most of your time doing?

Put 1 for Therapist
Put 2 for Supervisor
Put 3 for Faculty

Thank- you for your help and commitment to the field! Please review your survey, be sure you have answered every question then click on the finished button below

Please check your answers. When you are done, push the button below.

finished

Thank You!

APPENDIX B
COAMFTE ACCREDITATION STANDARDS

PREAMBLE TO STANDARDS ON ACCREDITATION
VERSION 10.2

Accreditation is a voluntary process on the part of the program whose major purpose is to ensure quality in a marriage and family therapy program. All accredited programs are expected to meet or exceed all standards of accreditation throughout their period of accreditation.

The integrity of an institution and the program is fundamental and critical to the process of accreditation.

Accreditation standards are usually regarded as minimal requirements for quality training.

All accredited programs are free to include other requirements, which they deem necessary and contribute to the overall quality of the program.

Programs must continually evaluate their programs in relation to their institution's mission and their own program mission, goals and educational objectives.

Accreditation standards, like other aspects of accreditation, are part of a slowly evolving, continuous process.

In the long view, there are continuing conversations among accreditors, training programs, trainees, trained professionals, employers, and consumers from which the standards and other aspects of accreditation evolve.

The Commission has the ability to change standards as needed to meet the changing needs of the profession.

This version includes some substantive changes from Version 9.0 and editing to eliminate redundancies and to clarify extant standards.

The Commission is earnestly interested in, and actively seeks, all comments and suggestions for modification and improvement to these standards and the process.

We all seek the same goal: the best training, the most competent professionals, and the best service to the public that is realistic and available.

The objective of these standards is to assure, as much as possible, that individuals trained in accredited programs are competently trained to become marriage and family therapists at the entry and doctoral levels.

The standards are designed to be unique to the practice and supervision of marriage and family therapy.

Some standards apply to training programs in general, including elements such as organizational stability, faculty accessibility, appropriate student selection processes, and fairness to students and employees.

Some standards apply to all psychotherapy training, including elements such as adequate numbers of client contact hours and supervision hours.

The standards apply to the training of marriage and family therapists and are based on a relational view of life in which an understanding and respect for diversity and non-discrimination are fundamentally addressed, practiced, and valued.

Based on this view, marriage and family therapy is a professional orientation toward life and is applicable to a wide variety of circumstances, including individual, couple, family, group, and community problems.

It is not a modality of treatment or of diagnosis.

It applies to all living systems; not only to persons who are married or who have a conventional family.

The Commission believes that a great area of concern for our profession and accredited programs is the inclusion of racial diversity in our training contexts and in the student body of our programs. However, we have removed all diversity standards pertaining to numbers of individuals.

Programs will be able to decide for themselves whether they want to enhance diversity in their training contexts or maintain the status quo.

The Commission also seeks to enhance the diversity of our programs in terms of age, culture, ethnicity, gender, physical ability, religion, sexual orientation, and socio-economic status, without disregarding the rights of religiously affiliated institutions and institutions outside of the United States.

Religiously affiliated institutions that have core beliefs directed toward conduct within their communities are entitled to protect those beliefs.

All institutions are exempt from those standards that would require them to violate the laws of their states or provinces.

Graduates from COAMFTE accredited marriage and family therapy programs are trained to be clinical mental health practitioners.

COAMFTE adopts the Standard Occupational Classification of the Bureau of Labor and Statistics which states that MFTs are qualified to [d]iagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. [They] Apply psychotherapeutic and family systems theories and techniques in the delivery of professional services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.

As a marriage and family therapist, all training is relational, related to context, and culturally sensitive, whether contact hours are relational or individual, whether diagnostic procedure is traditional or relational, and whether a presenting problem is explicitly related to a marriage, a family, or to neither.

The standards, for instance, require a minimum number of relational contact hours (direct client contact with more than one partner or family member in the therapy room), although all accredited programs also include a large number of contact hours that are not relational in this sense.

All persons properly trained in marriage and family therapy are to be competent in working with individuals.

The standards emphasize the relational hour requirement because this is the more exceptional aspect of the profession of marriage and family therapy.

Standards of Accreditation, Version 10.2

100-199: All Accredited Programs

100: Professional Identity

100.01 The program will have clearly specified educational objectives, consistent with the institution and the program's mission and appropriate to the profession of marriage and family therapy.

100.02 The program will be clearly identifiable as training students in the profession of marriage and family therapy.

100.03 Education in the profession of marriage and family therapy will be based on a systems/relational understanding of people's lives.

100.04 The program will demonstrate that it provides a learning context in which understanding and respect for diversity and non-discrimination are fundamentally addressed, practiced, and valued in the curriculum, program structure, and clinical training.

100.05 Programs will establish their own definition of diversity, which will include race, religion, culture, etc. Programs will provide a rationale for establishing their definition and a plan to achieve diversity. The plan will establish benchmarks by which the Commission can evaluate the progress of the program in achieving its own stated definition of diversity.

110: Leadership

110.01 Programs will be operated by at least three marriage and family therapy faculty, consisting of a minimum of two AAMFT Approved Supervisors and a third individual who will be an Approved Supervisor, Supervisor-in-Training, or the equivalent.

110.02 The Program Director, or whoever has or shares ultimate program responsibilities, will be an AAMFT Approved Supervisor. Equivalency or Supervisor-in-Training status does not fulfill this standard.

110.03 Program Director responsibilities will include the clinical training program, facilities, and services, and the responsibility for maintenance and enhancement of program quality.

110.04 When director responsibilities are shared by more than one person, responsibilities will be clearly defined.

110.05 The program will be directed on a 12-month basis.

120: Organization

120.01 The program will be in a stable organizational structure.

120.02 The program will have been in operation for at least two years.

120.03 The program will have strong administrative support.

120.04 The program will demonstrate responsible conduct in administrative, organizational, financial, and personnel matters, using generally accepted policies and procedures.

120 05 The program or the institution will publish and adhere to policies prohibiting discrimination on the basis of age, culture, ethnicity, gender, physical ability, nationality, race, religion, and sexual orientation.

120.06 The program will have graduated at least one class of students.

120.07 The program will maintain on file syllabi for all didactic courses taught that comprise the program curriculum, including documentation of appropriate and substantial course content, and methods for evaluating student performance.

120.08 Programs will maintain academic records (transcripts) on file; they must publish catalogs and academic calendars; published promotional materials and advertising cannot be false or misleading; and admissions and grading policies (evaluations) must be written and provided to students.

120.09 The institution will be accredited by the appropriate regional accrediting body, if an academic degree is granted

120.10 The institution will be chartered or licensed by the appropriate state authority, if applicable.

120.11 The program will maintain clear relationships and regular liaison with all sites of clinical work, which will be specified, in a written agreement.

120.12 All clinical records and interviews will be kept confidential, in compliance with ethical standards of the profession, except when in conflict with applicable law and judicial interpretation.

120.13 The program will provide information to prospective students regarding the racial and cultural diversity of the MFT faculty, supervisors and student body.

130: Program Personnel

130.01 Program faculty will be actively engaged in scholarship through contributions at the local, regional, national, or international level.

130.02 All program faculty and supervisors will be engaged in direct client contact (as defined in Standard 151.01).

130.03 Program faculty will have the freedom and responsibility to conduct the program.

130.04 Program faculty will be available to students and will be active participants in their didactic and clinical training.

130.05 No student will be admitted to the program without the assent of the program faculty.

130.06 Responsibility for teaching couple and family therapy in degree-granting programs will be vested principally in a full-time marriage and family therapy faculty.

130.07 Program faculty will have training, experience, and a demonstrated ability in teaching the material that is their responsibility.

130.09 Program faculty and supervisors are to demonstrate personal and professional integrity, including but not limited to compliance with the AAMFT Code of Ethics.

140: Students

140.01 The program will have and adhere to clearly defined and published policies and procedures for assessing recruitment of prospective students, applicants' qualifications and readiness for admission into the program.

140.02 The program will have established policies for informing applicants and students regarding disclosure of their personal information.

140.03 The program will inform students about how credentials earned in the program relate to eligibility for AAMFT Clinical Membership, state licensure and certification, eligibility for employment, salary expectations, and post degree requirements for credentialing.

140.04 For each student, the program will maintain on file, and keep up to date, a transcript, documentation of the basis for admission, and documentation of the student's progress (including the number of client contact and supervision hours accrued).

140.05 Programs will have and inform students of available student support services. These services may include, but not be limited to, clear institution policies and requirements needed for completing professional educational requirements, the availability of social and psychological counseling services for students, and employment opportunities in the field.

140.06 The program will have published policies and procedures in keeping with generally accepted practices, for refunding fees to students who withdraw, and for dealing with student grievances. Programs will maintain records of student grievances received.

140.07 The program will document that all students are covered by liability insurance.

140.08 Students are to demonstrate personal and professional integrity, including but not limited to compliance with the AAMFT Code of Ethics.

140.09 The program will have and adhere to published policies and procedures for evaluating students, which will include verification of completing program requirements.

140.10 Evaluation of the progress and performance of each student will give the student a clear representation of strengths and weaknesses.

140.11 The program will provide students with evaluations of their conceptual knowledge and understanding of the couple, marriage, and family therapy literature.

140.12 The program will provide students with evaluations of their knowledge of and adherence to the AAMFT Code of Ethics and pertinent laws.

140.13 The program will provide students with evaluations of their clinical skills.

140.14 Students will be given the opportunity to evaluate the program, including course work; clinical practice; supervision (competency and availability); and faculty (competency and availability).

140.15 The program will solicit and review information for program improvement from graduates two years after graduation that will include, but not be limited to, the following information: professional employment status, credentialing status, preparedness to function in the workplace, and student satisfaction with education.

140.16 The program will develop mechanisms to document success in student achievement for program improvement in relation to the program's mission including, but not limited to: state licensure rates or clinical membership rates in AAMFT; rates for graduation and employment in the field; and student satisfaction ratings.

140.17 For entering a non-degree granting program, an applicant must already hold a degree comparable to a master's. The institution granting the prior degree must be appropriately accredited, in keeping with generally accepted customs and traditions for the degree discipline, in the country or region of the institution.

150: Clinical Experience

151: Contact Hours

151.01 Direct client contact is defined as face-to-face (therapist and client) therapy with individuals, couples, families, and/or groups from a relational perspective. Activities such as telephone contact, case planning, observation of therapy, record keeping, travel, administrative activities, consultation with community members or professionals, or supervision, are not considered direct client contact. Assessments may be counted as direct client contact if they are face-to-face processes that are more than clerical in nature and focus. Psychoeducation may be counted as direct client contact.

152: Supervision

152.01 Supervision of students, when conducted in fulfillment of clinical requirements of these standards, will be face-to-face or live supervision conducted by AAMFT Approved Supervisors, Supervisors-in-Training, or the equivalent. If a student is simultaneously being supervised and having direct client contact, the time may be counted as both supervision time and direct client contact time.

152.02 A program may designate a person who is not an AAMFT Approved Supervisor as equivalent to that status, for purposes of supervision if the person is an AAMFT Supervisor-in-Training. A program may designate a person who is not an AAMFT Approved Supervisor or Supervisor-in-Training as equivalent to an AAMFT Approved Supervisor for purposes of supervision, if (1) the program documents that the equivalent supervisor has demonstrated training, education and experience in marriage and family therapy. This may be demonstrated by state MFT credential, AAMFT clinical membership or other documentation of training, education and experience in marriage and family therapy, and (2) demonstrated training, education and experience in marriage and family therapy supervision. This may be demonstrated by state credential to provide MFT supervision, completing coursework or continuing education in MFT supervision, significant MFT supervised supervision experience, or more than 10 years experience supervising MFT students (Equivalency criteria must include training in MFT supervision.).

152.03 The program will have access to videotape, audiotape, or direct observation of students' clinical work, at all sites of clinical work.

152.04 Programs will have and adhere to written policies and procedures governing the transportation, storage, and transmission of confidential media.

152.05 Individual supervision is defined as supervision of one or two individuals.

152.06 When a supervisor is conducting live supervision, only the therapist(s) in the room with the client (up to two therapists) may count the time as individual supervision.

152.07 Group supervision will not exceed six students per group.

152.08 Students observing someone else's clinical work may receive credit for group supervision provided that (1) at least one supervisor is present with the students, (2) there are no more than six students altogether, and (3) the supervisory experiences involve an interactional process between the therapist(s), the observing students, and the supervisor. If there are no more than two students, the observing student may receive credit for individual supervision under the same conditions.

152.09 Supervision will be distinguishable from psychotherapy or teaching.

152.10 Published program materials will inform applicants that they will receive individual supervision, group supervision, and supervision based on direct observation, videotape, or audiotape.

152.11 Supervision of students by fellow students in the same department is permitted given all of the following conditions: (1) the supervised student is explicitly informed that it is permissible to decline, (2) the supervision is closely supervised by a non-student Approved Supervisor or the equivalent, (3) the supervising student has completed or is presently in a graduate course in family therapy supervision, (4) the supervision time does not count toward COAMFTE supervision hour requirements of the supervised student, and (5) special attention is given to power and privilege in the supervisory relationships involved.

160: Facilities

160.01 The program will have access to library facilities with sufficient quantities and kinds of relevant books, journals, and other educational and research media.

160.02 There will be one or more clinical sites for which the program has broad, but not necessarily sole, responsibility for supervision and clinical practice of individual, couple and family therapy as carried out by program students. The facilities will offer these services to the public.

160.03 Clinical facilities used for training purposes will operate on a 12-month calendar year basis.

160.04 Clinical facilities will be adequate and conducive to clinical practice.

160.05 Clinical facilities will have policies and procedures concerning professional practice and informed consent of clients; including but not limited to such areas as client rights, limits of confidentiality, and the establishment and collection of fees.

160.06 Clinical facilities will have reasonable policies and procedures concerning safety, privacy, and confidentiality.

160.07 The type of services rendered at clinical facilities and the training status of the therapist will be accurately and well represented to the public.

170: Coursework Measurement

170.01 A Standard Didactic Unit (SDU) is a group of instructional interactions that is equivalent, in a degree granting institution, to a customary three-credit course operated on a semester system and to a customary four-credit course in a quarter system. In non-degree granting institutions, an SDU is equivalent to a minimum of 30 instructional hours. One three-credit course cannot be counted as more than one SDU by any program. Programs are able to divide courses among SDUs and areas. A portion of one course could be used for one area while the other portion could be used for another area. As long as the sum of student experiences adds up to the required SDU minimum, programs can document SDUs in a variety of ways. Clinical experience requirements such as practicum or internship (as documented in Section 400) cannot be counted as SDUs.

200-299: Standard Curriculum

200.01 The program will document that all students have completed, or will complete while in the program, all coursework and clinical requirements of the standard curriculum, or equivalents thereof. A transcript of completed requirements will be kept on file.

200.02 A master's degree program will offer to its students the entire standard curriculum as presented in this manual.

200.03 A non-degree-granting program will offer to its students at least four SDUs from Areas I and II. It will offer to its students at least one SDU from Area I and at least one SDU from Area II. The program decides which of the areas it increases beyond the minimum to arrive at the four SDUs.

300-399: Standard Curriculum Didactic Area Requirement

300.01 Programs are expected to infuse their curriculum with content that addresses issues related to diversity and power and privilege as they relate to age, culture, environment, ethnicity, gender, health/ability, nationality, race, religion, sexual orientation, spirituality, and socioeconomic status.

300.02 The Standard Curriculum will address appropriate collaboration with other disciplines.

300.03 Either during the program or before it, students will complete 12 SDUs in the standard curriculum, Areas I-VI.

300.04 Either during the program or before it, students will complete 9 SDUs in Areas I, II, and III (see descriptions below). Students will take a minimum of seven SDUs in Areas II and III. Students will complete a minimum of four SDUs in Area II and one SDU in Area III. The program decides which of the areas it increases beyond the minimum to arrive at the seven SDUs.

310: Area I: Theoretical Knowledge

310.01 Either during the program or before it, students will complete a minimum of two SDUs in Area I.

310.02 Area I content will address the historical development, theoretical and empirical foundations, and contemporary conceptual directions of the field of marriage and family therapy.

310.03 Area I content will enable students to conceptualize and distinguish the critical epistemological issues in the profession of marriage and family therapy.

310.04 Area I material will provide a comprehensive survey and substantive understanding of the major models of marriage, couple, and family therapy.

310.05 Area I content will be related conceptually to clinical concerns.

320: Area II: Clinical Knowledge

320.01 During the program or before it, students will complete a minimum of four SDUs in Area II.

320.02 Area II content will address, from a relational/systemic perspective, psychopharmacology, physical health and illness, traditional psychodiagnostic categories, and the assessment and treatment of major mental health issues.

320.03 Area II material will address couple and family therapy practice and be related conceptually to theory.

320.04 Area II content will address contemporary issues, which include but are not limited to gender, violence, addictions, and abuse, in the treatment of individuals, couples, and families from a relational/systemic perspective.

320.05 Area II material will address a wide variety of presenting clinical problems.

320.06 Area II will include content on issues of gender and sexual functioning, sexual orientation, and sex therapy as they relate to couple, marriage and family therapy theory and practice.

320.07 Area II content will include significant material on diversity and discrimination as it relates to couple and family therapy theory and practice.

330: Area III: Individual Development and Family Relations

330.01 Students will take a minimum of one SDU in Area III.

330.02 Area III will include content on individual development across the life span.

330.03 Area III will include content on family development across the life span.

340: Area IV: Professional Identity and Ethics

340.01 Students will take a minimum of one SDU in Area IV.

340.02 Area IV content will include professional identity, including professional socialization, scope of practice, professional organizations, licensure, and certification.

340.03 Area IV content will focus on ethical issues related to the profession of marriage and family therapy and the practice of individual, couple, and family therapy. A generic course in ethics does not meet this standard.

340.04 Area IV will address the AAMFT Code of Ethics, confidentiality issues, the legal responsibilities and liabilities of clinical practice and research, family law, record keeping, reimbursement, and the business aspects of practice.

340.05 Area IV content will inform students about the interface between therapist responsibility and the professional, social, and political

350: Area V: Research

350.01 Students will take a minimum of one SDU in Area V.

350.02 Area V content will include significant material on research in couple and family therapy.

350.03 Area V content will focus on research methodology, data analysis and the evaluation of research.

350.04 Area V content will include quantitative and qualitative research.

360: Area VI: Additional Learning

360.01 Students will take a minimum of one SDU in Area VI.

360.02 Additional learning will augment students' specialized interest and background in individual, couple, and family therapy. Additional courses may be chosen from coursework offered in a variety of disciplines.

Standard Curriculum Didactic Area Requirements

Areas of Study	Minimum Requirements
I. Theoretical Foundations	2 SDUs
II. Clinical Practice	4 SDUs
III. Individual Development and Family Relations	1 SDU
Total Required for Areas I, II, and III (the program will decide which of the areas it increases beyond the minimum)	9 SDUs

IV.	Professional Identity and Ethics	1 SDU
V.	Research	1 SDU
VI.	Additional Learning	1 SDU
	Total for Areas I through VI	12 SDUs

400-499: Standard Curriculum Clinical Experience Requirements

401: Contact Hours

401.01 Students will complete a minimum of 500 supervised, direct client contact hours. At least 400 of these hours must be direct client contact fitting the criteria specified in Standard 151.01. Up to 100 hours may consist of alternative therapeutic contact that is systemic and interactional.

401.02 At least 250 hours (of the required 500 hours of client contact) will occur in clinical facilities fitting the criteria stated in Standard 160.02.

401.03 At least 250 (of the required 500 hours of client contact) will be with couples or families present in the therapy room.

401.04 Students will work with a wide variety of people, relationships, and problems.

401.05 The program will publish and adhere to criteria for determining when students are prepared for clinical practice.

401.06 Published promotional materials will inform applicants that they must complete 500 direct client contact hours.

401.07 Clinical work will not be interrupted for arbitrary student, administrative, or didactic scheduling reasons, when interruption would be harmful to clients.

401.08 Programs will demonstrate that students have the opportunity to work with clients who are diverse in terms of age, culture, physical ability, ethnicity, family composition, gender, race, religion, sexual orientation and socioeconomic status.

410: Supervision

410.01 Students will receive at least 100 hours of face-to-face supervision.

410.02 Students will receive at least one hour of supervision for every five hours of direct client contact.

410.03 Supervision will occur at least once every week in which students have direct client contact hours.

410.04 Individual supervision will occur at least once every other week in which students have direct client contact hours.

410.05 Students will receive at least 50 hours of supervision based on direct observation, videotape, or audiotape. At least 25 hours of this supervision will be based on direct observation or videotape.

410.06 Students should be given opportunities to observe their supervisors' clinical work. In this context, "clinical work" includes therapy in progress, clinical evaluation in progress, and role playing.

410.07 Group supervision is required.

500-599: Doctoral Programs

501: Didactic Requirements

501.01 Doctoral programs will include a minimum of 14 SDUs of post-master's coursework in Areas VII-XII.

501.02 Doctoral programs will have available and will offer the standard curriculum to all students who have not graduated from a master's program accredited by the Commission on Accreditation for Marriage and Family Therapy Education.

509: Areas VII, VIII, IX: Theory, Clinical Practice and Individual Development and Family Relations

509.01 Areas VII, VIII, IX are continuations of Areas I, II, and III, respectively, at a doctoral level of sophistication.

509.02 Students will take a minimum of four SDUs in Areas VII, VIII, and IX. Students will take courses in at least two of the three areas.

510: Area X: Clinical Supervision

510.01 Students will take a minimum of one SDU in Area X.

510.02 Area X course content will be didactic and experiential, and will include current literature, research and major issues related to supervision in the profession of marriage and family therapy.

511: Area XI: Research

511.01 Students will take a minimum of four SDUs in Area XI.

511.02 Courses in Area XI will provide comprehensive coverage of the critique and execution of couple, marriage, and family therapy research, statistics, research methodologies, and computer analysis and interpretation, in qualitative and quantitative research.

511.03 Students will take a minimum of one SDU with a specific focus on couple, marriage, and family therapy research.

512: Area XII: Additional Courses

512.01 Additional courses will augment students' specialized interests and backgrounds in couple, marriage, and family therapy. Additional courses may be chosen from coursework offered in a variety of disciplines.

Doctoral Curriculum Didactic Requirements

(Students must complete the standard curriculum prior to the doctoral curriculum.)

Areas of Study	Minimum Requirements
VII. Theory Students will take courses in at least two of the areas to arrive at the total required.	
VIII Clinical Practice	
IX. Individual Development and Family Relations	
Total Required for Areas VII, VIII, and IX	4 SDUs
X. Clinical Supervision	1 SDU
XI. Research	4 SDUs
XII. Additional Courses as program chooses	
Total for Areas VII–XII (the program will decide which of the areas it increases to arrive at the total required)	14 SDUs

513: The Doctoral Dissertation

513.01 The doctoral dissertation may not be counted toward the 14 SDU total didactic requirement.

513.02 The doctoral dissertation topic will be in the field of marriage and family therapy.

520: Clinical Experience

520.01 Doctoral students will be involved in clinical practice.

520.02 Before graduating from the doctoral program, doctoral students will have completed 1000 hours of direct client contact equivalent to that which they would be receiving from an accredited program.

520.03 Doctoral students who can document that their previous supervised clinical practice is comparable to that which would be received in an accredited program, may petition the program to waive some or all of the required 1000 direct client contact hours.

520.04 The program will have established criteria for waiving direct client contact hours.

530: The Internship

530.01 There will be an internship, not to be counted toward the 14 SDU total didactic requirement.

530.02 The internship is to provide doctoral students with a supervised full-time experience of at least nine months duration, emphasizing relationally focused practice and/or research.

530.03 The majority of requirements in Areas VII, VIII, IX, and XI will be completed before the beginning of the internship.

540: Site Requirements

540.01 The program will maintain clear relationships with all internship site(s), which will be specified in a written document.

540.02 Activities of each intern will be documented at the internship site(s). These records will made available to the marriage and family therapy program.

540.03 The institution sponsoring the internship site(s) will have been in operation for at least two years.

540.04 Internship site(s) will provide adequate facilities and equipment for the intern to carry out designated responsibilities.

540.05 Mechanisms for student evaluation of internship site(s) and supervision, and site evaluation of the intern's performance, will be demonstrated.

540.06 Documentation of liability insurance for interns will be confirmed. Liability insurance may be provided by the internship site(s), the marriage and family therapy program, or the intern.

540.07 Internship site(s) will publish and adhere to policies prohibiting discrimination on the basis of age, culture, ethnicity, gender, physical ability, race, religion, sexual orientation, and socioeconomic status.

540.08 An AAMFT Approved Supervisor or the equivalent will supervise the intern's clinical work.

540.09 The internship supervisor will be available to the intern and will be an active participant in her/his training.

540.10 The internship supervisor will be clearly senior in experience to the intern.

APPENDIX C
AAMFT CODE OF ETHICS

AAMFT Code of Ethics
Effective July 1, 2001

Preamble

The Board of Directors of the American Association for Marriage and Family Therapy (AAMFT) hereby promulgates, pursuant to Article 2, Section 2.013 of the Association's Bylaws, the Revised AAMFT Code of Ethics, effective July 1, 2001.

The AAMFT strives to honor the public trust in marriage and family therapists by setting standards for ethical practice as described in this Code. The ethical standards define professional expectations and are enforced by the AAMFT Ethics Committee. The absence of an explicit reference to a specific behavior or situation in the Code does not mean that the behavior is ethical or unethical. The standards are not exhaustive. Marriage and family therapists who are uncertain about the ethics of a particular course of action are encouraged to seek counsel from consultants, attorneys, supervisors, colleagues, or other appropriate authorities.

Both law and ethics govern the practice of marriage and family therapy. When making decisions regarding professional behavior, marriage and family therapists must consider the AAMFT Code of Ethics and applicable laws and regulations. If the AAMFT Code of Ethics prescribes a standard higher than that required by law, marriage and family therapists must meet the higher standard of the AAMFT Code of Ethics. Marriage and family therapists comply with the mandates of law, but make known their commitment to the AAMFT Code of Ethics and take steps to resolve the conflict in a responsible manner. The AAMFT supports legal mandates for reporting of alleged unethical conduct.

The AAMFT Code of Ethics is binding on Members of AAMFT in all membership categories, AAMFT-Approved Supervisors, and applicants for membership and the Approved Supervisor designation (hereafter, AAMFT Member). AAMFT members have an obligation to be familiar with the AAMFT Code of Ethics and its application to their professional services. Lack of awareness or misunderstanding of an ethical standard is not a defense to a charge of unethical conduct.

The process for filing, investigating, and resolving complaints of unethical conduct is described in the current Procedures for Handling Ethical Matters of the AAMFT Ethics Committee. Persons accused are considered innocent by the Ethics Committee until proven guilty, except as otherwise provided, and are entitled to due process. If an AAMFT Member resigns in anticipation of, or during the course of, an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the Association will include the fact that the Member attempted to resign during the investigation.

Contents

Principle I

Responsibility to Clients

Marriage and family therapists advance the welfare of families and individuals They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately.

1.1 Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation.

1 2 Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship, and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible.

1.3 Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

1.4 Sexual intimacy with clients is prohibited.

1.5 Sexual intimacy with former clients is likely to be harmful and is therefore prohibited for two years following the termination of therapy or last professional contact. In an effort to avoid exploiting the trust and dependency of clients, marriage and family therapists should not engage in sexual intimacy with former clients after the two years following termination or last professional contact. Should therapists engage in sexual intimacy with former clients following two years after termination or last professional contact, the burden shifts to the therapist to demonstrate that there has been no exploitation or injury to the former client or to the client's immediate family.

1.6 Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct

1.7 Marriage and family therapists do not use their professional relationships with clients to further their own interests

1.8 Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise the clients that they have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

1.9 Marriage and family therapists continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship.

1.10 Marriage and family therapists assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help.

1.11 Marriage and family therapists do not abandon or neglect clients in treatment without making reasonable arrangements for the continuation of such treatment.

1.12 Marriage and family therapists obtain written informed consent from clients before videotaping, audio recording, or permitting third-party observation.

1.13 Marriage and family therapists, upon agreeing to provide services to a person or entity at the request of a third party, clarify, to the extent feasible and at the outset of the service, the nature of the relationship with each party and the limits of confidentiality.

Principle II

Confidentiality

Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard the confidences of each individual client.

2.1 Marriage and family therapists disclose to clients and other interested parties, as early as feasible in their professional contacts, the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.

2.2 Marriage and family therapists do not disclose client confidences except by written authorization or waiver, or where mandated or permitted by law. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law. When providing couple, family or group treatment, the therapist does not disclose information outside the treatment context without a written authorization from each individual competent to execute a waiver. In the context of couple, family or group treatment, the therapist may not reveal any individual's confidences to others in the client unit without the prior written permission of that individual.

2.3 Marriage and family therapists use client and/or clinical materials in teaching, writing, consulting, research, and public presentations only if a written waiver has been obtained in accordance with Subprinciple 2.2, or when appropriate steps have been taken to protect client identity and confidentiality.

2 4 Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.

2.5 Subsequent to the therapist moving from the area, closing the practice, or upon the death of the therapist, a marriage and family therapist arranges for the storage, transfer, or disposal of client records in ways that maintain confidentiality and safeguard the welfare of clients.

2.6 Marriage and family therapists, when consulting with colleagues or referral sources, do not share confidential information that could reasonably lead to the identification of a client, research participant, supervisee, or other person with whom they have a confidential relationship unless they have obtained the prior written consent of the client, research participant, supervisee, or other person with whom they have a confidential relationship. Information may be shared only to the extent necessary to achieve the purposes of the consultation.

Principle III

Professional Competence and Integrity

Marriage and family therapists maintain high standards of professional competence and integrity.

3.1 Marriage and family therapists pursue knowledge of new developments and maintain competence in marriage and family therapy through education, training, or supervised experience.

3.2 Marriage and family therapists maintain adequate knowledge of and adhere to applicable laws, ethics, and professional standards.

3.3 Marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may impair work performance or clinical judgment.

3.4 Marriage and family therapists do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

3.5 Marriage and family therapists, as presenters, teachers, supervisors, consultants and researchers, are dedicated to high standards of scholarship, present accurate information, and disclose potential conflicts of interest.

3.6 Marriage and family therapists maintain accurate and adequate clinical and financial records.

3.7 While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, or supervised experience.

3.8 Marriage and family therapists do not engage in sexual or other forms of harassment of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.9 Marriage and family therapists do not engage in the exploitation of clients, students, trainees, supervisees, employees, colleagues, or research subjects.

3.10 Marriage and family therapists do not give to or receive from clients (a) gifts of substantial value or (b) gifts that impair the integrity or efficacy of the therapeutic relationship.

3.11 Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies

3.12 Marriage and family therapists make efforts to prevent the distortion or misuse of their clinical and research findings.

3.13 Marriage and family therapists, because of their ability to influence and alter the lives of others, exercise special care when making public their professional recommendations and opinions through testimony or other public statements

3.14 To avoid a conflict of interests, marriage and family therapists who treat minors or adults involved in custody or visitation actions may not also perform forensic evaluations for custody, residence, or visitation of the minor. The marriage and family therapist who treats the minor may provide the court or mental health professional performing the evaluation with information about the minor from the marriage and family therapist's perspective as a treating marriage and family therapist, so long as the marriage and family therapist does not violate confidentiality.

3.15 Marriage and family therapists are in violation of this Code and subject to termination of membership or other appropriate action if they: (a) are convicted of any felony; (b) are convicted of a misdemeanor related to their qualifications or functions; (c) engage in conduct which could lead to conviction of a felony, or a misdemeanor related to their qualifications or functions; (d) are expelled from or disciplined by other professional organizations; (e) have their licenses or certificates suspended or revoked or are otherwise disciplined by regulatory bodies; (f) continue to practice marriage and family therapy while no longer competent to do so because they are impaired by physical or mental causes or the abuse of alcohol or other substances; or (g) fail to cooperate with the Association at any point from the inception of an ethical complaint through the completion of all proceedings regarding that complaint.

Principle IV

Responsibility to Students and Supervisees

Marriage and family therapists do not exploit the trust and dependency of students and supervisees.

4.1 Marriage and family therapists are aware of their influential positions with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships that could impair professional objectivity or increase the risk of exploitation. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists take appropriate precautions.

4.2 Marriage and family therapists do not provide therapy to current students or supervisees.

4.3 Marriage and family therapists do not engage in sexual intimacy with students or supervisees during the evaluative or training relationship between the therapist and student or supervisee. Should a supervisor engage in sexual activity with a former supervisee, the burden of proof shifts to the supervisor to demonstrate that there has been no exploitation or injury to the supervisee.

4.4 Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.

4.5 Marriage and family therapists take reasonable measures to ensure that services provided by supervisees are professional.

4.6 Marriage and family therapists avoid accepting as supervisees or students those individuals with whom a prior or existing relationship could compromise the therapist's objectivity. When such situations cannot be avoided, therapists take appropriate precautions to maintain objectivity. Examples of such relationships include, but are not limited to, those individuals with whom the therapist has a current or prior sexual, close personal, immediate familial, or therapeutic relationship.

4.7 Marriage and family therapists do not disclose supervisee confidences except by written authorization or waiver, or when mandated or permitted by law. In educational or training settings where there are multiple supervisors, disclosures are permitted only to other professional colleagues, administrators, or employers who share responsibility for training of the supervisee. Verbal authorization will not be sufficient except in emergency situations, unless prohibited by law.

Principle V

Responsibility to Research Participants

Investigators respect the dignity and protect the welfare of research participants, and are aware of applicable laws and regulations and professional standards governing the conduct of research.

5.1 Investigators are responsible for making careful examinations of ethical acceptability in planning studies. To the extent that services to research participants may be compromised by participation in research, investigators seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.

5.2 Investigators requesting participant involvement in research inform participants of the aspects of the research that might reasonably be expected to influence willingness to participate. Investigators are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, or have impairments which limit understanding and/or communication, or when participants are children.

5.3 Investigators respect each participant's freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid multiple relationships with research participants that could impair professional judgment or increase the risk of exploitation.

5.4 Information obtained about a research participant during the course of an investigation is confidential unless there is a waiver previously obtained in writing. When the possibility exists that others,

including family members, may obtain access to such information, this possibility, together with the plan for protecting confidentiality, is explained as part of the procedure for obtaining informed consent.

Principle VI

Responsibility to the Profession

Marriage and family therapists respect the rights and responsibilities of professional colleagues and participate in activities that advance the goals of the profession.

6.1 Marriage and family therapists remain accountable to the standards of the profession when acting as members or employees of organizations. If the mandates of an organization with which a marriage and family therapist is affiliated, through employment, contract or otherwise, conflict with the AAMFT Code of Ethics, marriage and family therapists make known to the organization their commitment to the AAMFT Code of Ethics and attempt to resolve the conflict in a way that allows the fullest adherence to the Code of Ethics.

6.2 Marriage and family therapists assign publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

6.3 Marriage and family therapists do not accept or require authorship credit for a publication based on research from a student's program, unless the therapist made a substantial contribution beyond being a faculty advisor or research committee member. Coauthorship on a student thesis, dissertation, or project should be determined in accordance with principles of fairness and justice.

6.4 Marriage and family therapists who are the authors of books or other materials that are published or distributed do not plagiarize or fail to cite persons to whom credit for original ideas or work is due.

6.5 Marriage and family therapists who are the authors of books or other materials published or distributed by an organization take reasonable precautions to ensure that the organization promotes and advertises the materials accurately and factually.

6.6 Marriage and family therapists participate in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return.

6.7 Marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest.

6.8 Marriage and family therapists encourage public participation in the design and delivery of professional services and in the regulation of practitioners.

Principle VII

Financial Arrangements

Marriage and family therapists make financial arrangements with clients, third-party payors, and supervisees that are reasonably understandable and conform to accepted professional practices.

7.1 Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referrals; fee-for-service arrangements are not prohibited.

7.2 Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related to professional services, including charges for canceled or missed appointments; (b) the use of collection agencies or legal measures for nonpayment; and (c) the procedure for obtaining payment from the client, to the extent allowed by law, if payment is denied by the third-party payor. Once services have begun, therapists provide reasonable notice of any changes in fees or other charges.

7.3 Marriage and family therapists give reasonable notice to clients with unpaid balances of their intent to seek collection by agency or legal recourse. When such action is taken, therapists will not disclose clinical information.

7.4 Marriage and family therapists represent facts truthfully to clients, third-party payors, and supervisees regarding services rendered.

7.5 Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it, (b) the relationship is not exploitative, (c) the professional relationship is not distorted, and (d) a clear written contract is established.

7.6 Marriage and family therapists may not withhold records under their immediate control that are requested and needed for a client's treatment solely because payment has not been received for past services, except as otherwise provided by law.

Principle VIII

Advertising

Marriage and family therapists engage in appropriate informational activities, including those that enable the public, referral sources, or others to choose professional services on an informed basis.

8.1 Marriage and family therapists accurately represent their competencies, education, training, and experience relevant to their practice of marriage and family therapy.

8.2 Marriage and family therapists ensure that advertisements and publications in any media (such as directories, announcements, business cards, newspapers, radio, television, Internet, and facsimiles) convey information that is necessary for the public to make an appropriate selection of professional services. Information could include: (a) office information, such as name, address, telephone number, credit card acceptability, fees, languages spoken, and office hours; (b) qualifying clinical degree (see subprinciple 8.5); (c) other earned degrees (see subprinciple 8.5) and state or provincial licensures and/or certifications; (d) AAMFT clinical member status; and (e) description of practice.

8.3 Marriage and family therapists do not use names that could mislead the public concerning the identity, responsibility, source, and status of those practicing under that name, and do not hold themselves out as being partners or associates of a firm if they are not.

8.4 Marriage and family therapists do not use any professional identification (such as a business card, office sign, letterhead, Internet, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading, or deceptive.

8.5 In representing their educational qualifications, marriage and family therapists list and claim as evidence only those earned degrees: (a) from institutions accredited by regional accreditation sources recognized by the United States Department of Education, (b) from institutions recognized by states or provinces that license or certify marriage and family therapists, or (c) from equivalent foreign institutions.

8.6 Marriage and family therapists correct, wherever possible, false, misleading, or inaccurate information and representations made by others concerning the therapist's qualifications, services, or products.

8.7 Marriage and family therapists make certain that the qualifications of their employees or supervisees are represented in a manner that is not false, misleading, or deceptive.

8.8 Marriage and family therapists do not represent themselves as providing specialized services unless they have the appropriate education, training, or supervised experience.

This Code is published by:
American Association for Marriage and Family Therapy
112 South Alfred Street, Alexandria, VA 22314
Phone: (703) 838-9808 Fax: (703) 838-9805
www.aamft.org

Violations of this Code should be brought in writing to the attention of:
AAMFT Ethics Committee
112 South Alfred Street, Alexandria, VA 22314
Phone: (703) 838-9808 Fax: (703) 838-9805
email: ethics@aamft.org

APPENDIX D
INVITATION LETTER TO PARTICIPATE IN SURVEY

Dear Marriage and Family Therapist:

I invite you to participate in an important study on the current status of relationship violence in MFT graduate training programs. I know your time is valuable, so I have made it quick and easy to participate. If you go to the Web address below, you will find more details about the study, a way to contact me if you have questions, and the survey itself. Your participation is voluntary and totally anonymous. The survey can be completed and submitted online in about 15 minutes.

From the results, I hope to better understand the most commonly identified factors that MFT practitioners, approved supervisors, and MFT faculty consider important in the training, assessment, and treatment of relationship violence. Please consider your participation one way in which you can personally contribute to the growth of the field. Your viewpoint is important in this matter and your participation is greatly appreciated.

For more information and to participate, go to:

http://www.stetson.edu/~mbraccia/RVTS-simpletext.html

If this link does not click open immediately, copy and paste this link into your Internet browser.

Respectfully,

Principal Investigator:
Marie T. Bracciale, LMFT, CAP
AAMFT Approved Supervisor
Doctoral Candidate Counselor Education
University of Florida, MFT Program
mariebufl@aol.com

Faculty advisor:
Silvia Echevarria-Doan, Ph.D. LMFT, LCSW,
Associate Professor
Doctoral Committee Chair
Department of Counselor Education
University of Florida

APPENDIX E
FOLLOW-UP LETTER TO NONRESPONDENTS

Dear Marriage and Family Therapist:

Recently I invited you to participate in an important study on the current status of relationship violence in MFT graduate training programs. Your participation is very important.

If you e-mailed the survey, thank you very much for your participation.

If you haven't had the opportunity to do so yet, I would appreciate it greatly if you could take the time to help me with my research. The survey can be completed and submitted online in about 15 minutes.

I know that your time is valuable, so I have made it quick and easy to participate. If you go to the Web address below, you will find more details about the study, a way to contact me if you have questions, and the survey itself. Your participation is voluntary and totally anonymous.

From the results, I hope to better understand the most commonly identified factors that MFT practitioners, approved supervisors, and MFT faculty consider important in the training, assessment, and treatment of relationship violence. Please consider your participation one way in which you can personally contribute to the growth of the field. Your viewpoint is important in this matter and your participation is greatly appreciated.

For more information and to participate, go to:

http://www.stetson.edu/~mbraccia/RVTS-simpletext.html

If this link does not click open immediately, copy and paste this link into your Internet browser.

Respectfully,

Principal Investigator:
Marie T. Bracciale, LMFT, CAP
AAMFT Approved Supervisor
Doctoral Candidate Counselor Education
University of Florida, MFT Program
mariebufl@aol.com

Faculty advisor:
Silvia Echevarria-Doan, Ph.D. LMFT, LCSW,
Associate Professor
Doctoral Committee Chair
Department of Counselor Education
University of Florida

APPENDIX F
SAMPLE CODED RESPONSE FORM

Subj:	Form Response
Date:	2/14/2003 8:16:57 PM Eastern Standard Time
From:	Journeyzen
To:	mariebufl
To:	mariebufl@aol.com
Subject:	Form posted from America Online
X-Mailer:	Mozilla/4.0 (compatible; MSIE 4.01; AOL 5.0; Mac_PPC)
MIME-Version:	1.0
Content-type:	text/plain
Content-Length:	446

00exp=(RVTS)
01Date=pfDate
02Time=pfTime
03Adr=pfRemoteAddress
04v1=2
05v2=2
06v3=1
07v4=5
08v5=3
09v6=2
10v7=3
11v8=2
12v9=3
13v10=2
14v11=4
15v12=1
16v13=2
17v14=1
18v15=3
19v16=4
20v17=5
21v18=4
22v19=2
23v20=1
24sex=F
25Age=44
26Ed=16
27Cn=USA
28v25=1
29v26=4
30v27=0
33v28=0
34v29=1
35v30=2
36v31=3
37v32=3
38v33=journeyzen@aol.com

21 of 72
Include original text in reply.

APPENDIX G

DESCRIPTIVE STATISTICS MEAN RATINGS AND STANDARD DEVIATIONS ($N = 171$)

Item	Mean	*SD*
v1	4.95	0.919
v2	4.27	1.245
v3	3.96	1.320
v4	4.92	0.942
v5	4.63	1.137
v6	2.96	1.439
v7	3.18	1.477
v8	3.03	1.416
v9	3.05	1.394
v11	5.74	0.538
v12	5.81	0.473
v13	5.75	0.510
v14	5.06	1.083
v15	5.66	0.625
v16	5.64	0.630
v17	5.83	0.461
v18	5.46	0.876
v19	5.59	0.610
v20	4.11	1.355

Note. V10 was omitted from the analysis.

APPENDIX H

FACTOR CORRELATION MATRIX

Factor	1	2	3
1	1.000	.107	.328
2	.107	1.000	.314
3	.328	.314	1.000

Extraction Method: Principal Axis Factoring

Rotation Method: Promax with Kaiser Normalization

LIST OF REFERENCES

Adams, D. (1998). Treatment models of men who batter: A profeminist analysis. In K. Yllo & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp. 62-69). Newbury Park, CA: Sage.

Aguilar, R. J, & Nightingale, N. N. (1994). The impact of specific battering experiences on the self-esteem of abused women. *Journal of Family Violence, 9,* 35-45.

Alderondo, E. (1998). Perpetrators of domestic violence. In A. Bellack & M. Hersen (Eds.), *Comprehensive clinical psychology* (pp. 437-452). New York: Pergamon.

Alderondo, E., & Straus, M. A. (1994). Screening for physical violence in couple therapy: Methodological, practical, and ethical considerations. *Family Process, 33,* 425-439.

Alderondo, E., & Sugarman, D. B. (1996). Risk marker analysis of the cessation and persistence of wife assault. *Journal of Consulting and Clinical Psychology, 64,* 1010-1019.

Alexander, J. F., & Barton, C (1980). Intervention with delinquents and their families. Clinical, methodological, and conceptual issues. In J. Vincent (Ed.), *Advances in family intervention, assessment and theory* (pp. 53-87). Greenwich, CT: JAI Press.

Alexander, J. F., Holtzworth-Munroe, A., & Jameson, P. B. (1993). Research on the process and outcome of marriage and family therapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 302-323). New York: Wiley.

Alexander, P. C., Moore, S., & Alexander, E. R., III. (1991). What is transmitted in the intergenerational transmission of violence? *Journal of Marriage and the Family, 53,* 657-668.

Allen, C. M., & Straus, M. A. (1980). Resources, power and husband-wife violence. In M. A. Straus & G. T. Hotaling (Eds.), *The social causes of husband-wife violence* (pp. 188-210). Minneapolis: University of Minnesota Press.

Almeida, R., & Durkin, T. (1999). The cultural context model therapy for couples with domestic violence. *Journal of Marital and Family Therapy, 25,* 313-324.

Amatea, E. (2001). *Doctoral seminar in counselor education.* Unpublished course notes, Spring semester, 2001, University of Florida, Gainesville.

American Association for Marriage and Family Therapy (AAMFT). (2000). Call for presentations. *Family Therapy News, 31,* 5.

American Association for Marriage and Family Therapy (AAMFT). (2003a). *COAMFTE accreditation standards.* Washington, DC: Author.

American Association for Marriage and Family Therapy (AAMFT). (2003b). *Directory of MFT training programs accredited or in candidacy status by the commission on Accreditation of Marriage and Family Therapy Education.* Retrieved October 9, 2003, from http://www.aamft.org/Online_Directories/coamfte.htm

American Psychiatric Association (APA). (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anastasi, A. (1988). *Psychological testing.* New York: Macmillan.

Anderson, H. (1997). *Conversation, language, and possibilities.* New York: Basic Books.

Anderson, J. F., Holtzworth-Munroe, A., & Jameson, P. B. (1993). Research on the process and outcome of marriage and family therapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior therapy* (4th ed., pp. 595-630). New York: Wiley.

Archer, J. (2000). Sex difference in aggression between heterosexual partners: A meta-analytic review. *Psychobiological Bulletin, 126,* 651-680.

Armsworth, M. W., & Stronck, K. (1999). Intergenerational effects of incest on parenting: Skills, abilities, and attitudes. *Journal of Counseling and Development. 77,* 303-314.

Atkinson, B., Heath, A., & Chenail, R. (1991). Qualitative research and the legitimization of knowledge. *Journal of Martial and Family Therapy, 17,* 175-180.

Avis, J. M. (1992). Where are all the family therapists? Abuse and violence within families and family therapy's response. *Journal of Marital and Family Therapy, 18,* 225-232.

Avis, J. M. (1996). Deconstructing gender in family therapy. In F. P. Piercy, D. H. Sprenkle, & J. L. Wetchler (Eds.), *Family therapy sourcebook* (2nd ed., pp. 220-255). New York: Guilford.

Babbie, E. (1990). *Survey research methods* (2nd ed.). Belmont, CA: Wadsworth.

Babcock, J. C., Yerrington, T. P., Green, C., & Miller, S. (2001). *Psychophysiological profiles of batterers.* Unpublished manuscript, University of Houston.

Bachman, R., & Saltzman, L. E. (1995). *Violence against women: Estimates from the redesigned survey.* Washington, DC: U.S. Department of Justice, Office of Justice Programs.

Bagarozzi, D. (1983). Family therapy and the Black middle class. In F. J. Turner (Ed.), *Differential diagnosis and treatment in social work* (pp. 655-665). New York: Free Press.

Bandilla, W. (2001). *OSS.* In U.-D. Reips & M. Bosnjak (Eds.), *Dimensions of Internet Science* (pp. 193-207). Lengerich, Germany: Pabst Science Publishers.

Bandura, A. (1965). Influence of models' reinforcement contingencies in the acquisition of imitative responses. *Journal of Personality and Social Psychology, 1,* 589-595.

Bandura, A. (1973). *Aggression: A social learning analysis.* Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1977). *Social learning theory.* Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1982). The psychology of chance encounters and path life paths. *American Psychological Journal, 37,* 747-755.

Bandura, A. (1993). Perceived self-efficacy in cognitive development and functioning. *Educational Psychologist, 21*(2), 117-148.

Bandura, A. (1994). Self-efficacy. *Encyclopedia of Humane Behavior,* 4, 77-81. New York: Academic Press.

Bandura, A., & Walters, R. (1963). *Social learning and personality development.* New York: Holt, Rinehart, Winston.

Bateson, G., Jackson, D. D., Haley, J., & Weakland, J. H. (1956). Toward a theory of schizophrenia. *Behavioral Science, 1,* 251-264.

Bednar, R. L., Burlingame, G. M., & Masters, K. S. (1988). Systems of family treatment: Substance or semantics? *Annual Review of Psychology, 39,* 401-434.

Belfrage, H. (1998). Implementing the HCR-20 scheme for risk assessment in a forensic psychiatric hospital. *Journal of Forensic Psychiatry, 9,* 328-338.

Berkowitz, L. (1993). *Aggression: Its causes, consequences, and control* New York: McGraw-Hill.

Berry, D. (1998). *The domestic violence sourcebook.* Los Angeles: Lowell House.

Birnbaum, M. H. (2000). SurveyWiz and FactorWiz: JavaScript Web pages that make HTML forms for research on the Internet. *Behavior Research Methods, Instruments, and Computers, 32,* 339-346.

Blood, R. O., & Wolfe, D. M. (1960). *Husbands and wives.* Glencoe, IL: Free Press.

Board of Behavioral Science Examiners (BBSE). (2000). *State licensing board for professional counselors.* Sacramento, CA: Author.

Board of Behavioral Science Examiners (BBSE). (2004). *State licensing board for professional counselors.* Sacramento, CA: Author.

Bograd, M. (1984). Family systems approach to wife battering: A feminist critique. *American Journal of Orthopsychiatry, 54,* 558-568.

Bograd, M. (1988). Feminist perspectives on wife abuse. In K. Yllo & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp. 11-26). New York: Sage.

Bograd, M. (1992). Values in conflict: Challenges to family therapists' thinking. *Journal of Marital and Family Therapy, 18,* 245-256.

Bograd, M. (1999). Strengthening domestic violence theories: Intersections of race, class, sexual orientation, and gender. *Journal of Marital and Family Therapy, 23,* 275-290.

Bograd, M., & Mederos, F. (1999). Battering and couples therapy: Universal screening and selection of treatment modality. *Journal of Marital and Family Therapy, 25,* 291-312.

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders. *Psychological Bulletin, 123,* 123-142.

Borum, R. (2000). Assessing violence risk among youth. *Journal of Clinical Psychology, 56,* 1263-1288.

Boughner, S. R., Hayes, S. F., Bubenzer, D. L., & West, J. D. (1994). Use of standardized assessments instruments by marital and family therapists: A survey. *Journal of Marital and Family Therapy, 20,* 69-75.

Bowker, D. (1999). *Constructing the client-computer interface: Guidelines for design and implementation of Web-based surveys* (Summary Report 99-15). Pullman, WA: Washington State University, Social and Economic Sciences Research Center.

Bowker. L. (1983). *Beating wife beating.* Lexington, MA: Lexington Books.

Bowker, L. (1986). *Ending the violence: A guidebook based on the experiences of 1,000 battered wives.* Holmes Beach, FL: Learning Publications.

Bray, J. H., Williamson, D. S., & Malone, P. E. (1984). Personal authority in the family system: Development of a questionnaire to measure personal authority in intergenerational processes. *Journal of Marital and Family Therapy, 10,* 167-178.

Breunlin, D. M., & Schwartz, R. (1983). Why clinicians should bother with research. *The Family Therapy Networker,* 7(4), 22-27, 57-59.

Breunlin, D. M., Schwartz, R., & Mac Kune-Karrer, B. M. (1992). *Metaframeworks: Transcending the models of family therapy.* San Francisco: Jossey-Bass.

Broderick, C. (1993). *Understanding family process.* Newbury Park, CA: Sage.

Brown, P., & O'Leary, K. D. (1997). Wife abuse in intact couples: A review of couples treatment programs. In G. Kaufman-Kantor (Ed.), *Out of the darkness: Contemporary perspectives on family violence* (pp. 194-207). Thousand Oaks, CA: Sage.

Brownmiller, S. (1999). *In our time: Memoir of a revolution.* New York: Random House.

Burt, M. R. (1980). Cultural myths and supports for rape. *Journal of Personality and Social Psychology, 32,* 217-230.

Burt, M. R. (1983). Justifying personal violence: A comparison of rapists and the general public. *Victimology: An International Journal, 8*(3-4), 131-150.

Burt, M. R., & Albin, R. S. (1981). Rape myths, rape definitions, and probability of conviction. *Journal of Applied Social Psychology, 11,* 212-230.

Buss, A. H., & Durkee, A. (1957). An inventory for assessing different kinds of hostility. *Journal of Consulting Psychology, 21,* 343-349.

Cambell, D. T., & Stanley, J. C. (1963). *Experimental and quasi-experimental designs for research.* Washington, DC: American Educational Research Association.

Campbell, J. C. (1995). *Assessing dangerousness.* Newbury Park, CA: Sage.

Campbell, J. C. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health, 93,* 1089-1097.

Carden, A. D. (1994). Wife abuse and the wife abuser: Review and recommendations. *Counseling Psychologist, 22,* 539-582.

Carillo, R., & Tello, J. (Eds.). (1998) *Family violence and men of color: Healing the wounded male spirit.* New York: Springer.

Carlson, M., Harris, M. S., & Holden, G. (1999). Protective orders and domestic violence: Risk factors for re-abuse. *Journal of Family Violence, 9,* 99-111.

Carter, R. E. (1989). Residency training and the later use of marital and family therapy in psychiatric practice. *Journal of Marital and Family Therapy, 15,* 411-418.

Cascardi, M., & O'Leary, K. (1992). Depressive symptomatology, self-esteem, and self-blame in battered women. *Journal of Family Violence, 7,* 249-259.

Cattell, R. B. (1952). *Factor analysis: An introduction and manual for the psychologist and social scientist.* New York: Harper.

Cattell, R. B. (1994). Parallel proportional profiles and other principles of determining the choice of factors by rotation. *Psychometrika, 9,* 267-83.

Centers for Disease Control and Prevention. (2001). *WISQARS: National Center for Injury Prevention and Control.* Atlanta: Author.

Chase, C. I. (1969). Often is where you find it. *American Psychologist, 24,* 1043.

Choice, P., & Lamke, L. (1997). A conceptual approach to understanding abused women's stay/leave decisions. *Journal of Family Issues, 18,* 290-314.

Clark, H. H. (1969). Linguistic processes in deductive reasoning. *Psychological Review, 76,* 387-404.

Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). (1994). *Commission on Accreditation for Marriage and Family Therapy Education.* Washington, DC: Author.

Cohen, J. (1994). The earth is round ($p < .05$). *American Psychologist, 49,* 997-1003.

Coleman, S. B., Myers Avis, J., & Turin, M. (1990). A study of the role of gender in family therapy training. *Family Process, 29,* 365-374.

Cook, D. R., & Franz-Cook, A. (1984). A systemic approach to wife battering. *Journal of Marital and Family Therapy, 10,* 83-94.

Cook, T. D., & Campbell, D. T. (1979). *Quasi experimentation: Design and analysis issues for field settings.* Chicago: Rand McNally.

Corsi, J. (1999). Treatment for men who batter women in Latin America. *American Psychologist, 54*(1), 64.

Crawford, D. A. (1981). Treatment approaches with pedophiles. In M. Cook & K. Howels (Eds.), *Adult sexual interest in children* (pp. 181-217). New York: Academic Press.

Creswell, J. W. (1994). *Research design: Qualitative and quantitative approaches.* Thousand Oaks, CA: Sage.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16,* 297-334.

Cunradi, C. B., Caetano, R., & Schaefer, J. (2002). Socioeconomic predictors of intimate partner violence among White, Black, and Hispanic couples in the United States. *Journal of Family Violence, 127,* 4.

Daly, M. (1978). *Gyn/Ecology: The metaethics of radical feminism.* Boston: Beacon.

Davidson, T. (1978). *Conjugal crime: Understanding and changing the wife beating problem.* New York: Hawthorn.

de Becker, G. (1997). *The gift of fear.* New York: Dell.

Dillman, D. A. (1978). *Mail and telephone surveys: The total design method.* New York: Wiley.

Dillman, D. A. (2000). *Mail and Internet surveys: The tailored design method.* New York: Wiley.

Dillman, D. A., & Bowker, D. K. (2001). The Web questionnaire challenge to survey methodologist. In U.-D. Reips & M. Bosnjak, (Eds.), *Dimensions of Internet science* (pp. 159-178). Lengerich, Germany: Pabst Science.

Dillman, D. A., Tortora, R. D., & Bowker, D. (1998). *Principles for constructing Web surveys* (SESRC Technical Report 98-50). Pullman, WA: SESRC.

Dobash, R. E., & Dobash, R. P. (1979). *Violence against wives.* New York: Free Press.

Doherty, W. J., Lester, M. E., & Leigh, G. (1986). Marriage encounter weekends: Couples who win and couples who lose. *Journal of Marital and Family Therapy, 12,* 49-61.

Doherty, W. J., & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. *Journal of Marital and Family Therapy, 22*(1), 9-25.

Dolon, R., Hendricks, J., & Meagher, S. M. (1986). Police practices and attitudes toward domestic violence. *Journal of Police Science and Administration, 14(3),* 192-197.

Douglas, K. S., & Webster, C. (1999). The HCR-20 violence risk assessment scheme: Concurrent validity in sample of incarcerated offenders. *Criminal Justice and Behavior, 26,* 3-19.

Dunford, F. (2000). The San Diego Navy experiment: An assessment of interventions for men who assault their wives. *Journal of Consulting and Clinical Psychology, 68,* 468-476.

Dutton, D. G. (1995). *The batterer: A psychological profile.* New York: Harper Collins.

Dutton, D. G., & Hart, S. G. (1992). Evidence for long-term, specific effects of childhood abuse and neglect on criminal behavior in men. *International Journal of Offender Therapy and Comparative Criminology, 36,* 129-137.

Dutton, D. G., & Painter, S. L. (1981). Traumatic bonding: The development of emotional attachments in battered women and other relationships of intermittent abuse. *Victimology: An International Journal, 1*, 139-155.

Dutton, D. G., Saunders, K., Starzomski, A., & Bartholomew, K. (1994). Intimacy, anger and insecure attachment as precursors of abuse in intimate relationships. *Journal of Applied Social Psychology, 24,* 1367-1386.

Dutton, D. G., Starzowski, A., & Ryan, L. (1996). Antecedents of abusive personality and abusive behavior in wife assaulters. *Journal of Family Violence, 11,* 113-132.

Dutton, M. A. (1992). *Empowering and healing the battered woman: A model for assessment and intervention.* New York: Springer.

Eckhardt, C., Barbour, K. A., & Stuart, G. L. (1997). Anger and hostility in maritally violent men: Conceptual distinctions, measurement issues, and literature review. *Clinical Psychology Review,17,* 333-358.

Edleson, J. L., & Gruszynski, R. (1988). Treating men who batter: Four years of outcome data from the Domestic Abuse Project. *Journal of Social Service Research, 12,* 3-22.

Fagan, J. (1987). Cessation of family violence: Deterrence and dissuasion. In L. Ohlin & M. Tonry (Eds.), *Crime and justice: An annual review of research* (pp. 377-426). Chicago: University of Chicago Press.

Falicov, C. J. (1995). Training to think culturally: A multidimensional comparative framework. *Family Process, 34,* 373-388.

Family Violence Prevention Fund. (1993). *Men beating women--Ending domestic violence: A qualitative and quantitative study of public attitudes on violence against women.* New York: EDK Associates.

Feld, S. L., & Straus, M. A. (1989). Escalation and desistance of wife assault in marriage. *Criminology, 27,* 141-161.

Ferraro, K., & Johnson, J. (1983). How women experience battering: The process of victimization. *Social Problems, 30,* 325-339.

Figley, C. R., & Nelson, T. S. (1989). Basic family therapy skills, I: Conceptualization and initial findings. *Journal of Marital and Family Therapy, 15,* 349-365.

Finkelhor, D. (1983). Common features of family abuse. In D. Finkelhor, R. Gelles, G. Hotaling, & M. Straus (Eds.), *The dark side of families: Current family violence research* (pp. 11-28). Newbury Park, CA: Sage.

Fowler, F. J. (1988). *Survey research methods.* Newbury Park, CA: Sage.

French-Lazovik, G., & Gibson, C. L. (1984). Effects of verbally labeled anchor points on the distributional parameters of rating measures. *Applied Psychological Measurement, 8,* 49-57.

Freyd, M. (1923). T he graphic rating scale. *Journal of Educational Psychology, 13,* 51-57.

Gayford, J. J. (1975). Battered wives: A preliminary survey of 100 cases. *British Medical Journal, 1,* 194-197.

Geffner, R. (1995). *Relation between chronic trauma, family violence, ADHD and the brain.* San Diego, CA: Family Violence & Sexual Assault Institute.

Gelles, R. J. (1983). An exchange/social control theory. In D. Finkelhor, R. Gelles, G. Hotaling, & M. Straus (Eds.), *The dark side of families: Current family violence research* (pp. 84-93). Newbury Park, CA: Sage.

Gelles, R. J. (1987). *The violent home.* Newbury Park, CA: Sage.

Gelles, R. J. (1997). *Intimate violence in families.* Thousand Oaks, CA: Sage.

Gelles, R. J., & Maynard, P. E. (1987). A structural family systems approach to intervention in cases of family violence. *Family Relations, 36,* 270-275.

Gelles, R. J., & Straus, M. A. (1988). *Intimate violence.* New York: Simon and Schuster.

Gentemann, K. (1984). Wife beating: Attitudes of a non-clinical population. *Victimology, 9*(1), 109-119.

Giarretto, H. A. (1976). The treatment of father-daughter incest: A psycho-social approach. *Children Today, 5,* 34-35.

Gil, D. G. (1971). Violence against children. *Journal of Marriage and the Family, 33,* 637-638.

Giles-Sims, J. (1981). *Wife battering: A systems theory approach.* New York: Guilford.

Giles-Sims, J. (1985). A longitudinal study of battered children of battered wives. *Family Relations, 34,* 205-210.

Goldner, V. (1985). Feminism and family therapy. *Family Process, 24,* 31-47.

Goldner, V. (1988). Generation and gender: Normative and covert hierarchies. *Family Process, 27,* 17-33.

Goldner, V. (1992). Making room for both/and. *Family Therapy Networker, 16,* 54-62.

Goldner, V. (1998). The treatment of violence and victimization in intimate relationships. *Family Process, 37,* 263-286.

Goldner, V. (1999). Mortality and multiplicity: Perspectives on the treatment of violence in intimate life. *Journal of Marital and Family Therapy, 25,* 325-336.

Goldner, V., Penn, P., Sheinberg,, M., & Walker, G. (1990). Love and violence: Gender paradoxes in volatile attachments. *Family Process, 29,* 343-364.

Goldstein, D., & Rosenbaum, A. (1985). An evaluation of the self-esteem of maritally violent men. *Family Relations, 34,* 425-428.

Goldstein, P. J. (1985). The drug/violence nexus: A tripartite conceptual framework. *Journal of Drug Issues, 14,* 493-506.

Gondolf, E. W. (1985). *Men who batter: An integrated approach to stopping wife abuse.* Holmes Beach, FL: Learning Publications.

Gondolf, E. W. (1987a). Changing men who batter: A developmental model of integrated interventions. *Journal of Family Violence, 2,* 345-369.

Gondolf, E. W. (1987b). Evaluating programs for men who batter: Problems and prospects. *Journal of Family Violence, 2,* 95-108.

Gondolf, E. W. (1990). *Psychiatric response to family violence: Identifying and confronting neglected danger.* Lexington, MA: Lexington.

Gondolf, E. W., & Fisher, E. R. (1988). *Battered women as survivors: An alternative to treating learned helplessness.* Lexington, MA: Lexington Books.

Gondolf, E. W., & Fisher, E. R. (1991). Wife battering. In R. T. Ammerman & M. Hersen (Eds.), *Case studies in family violence* (pp. 273-292). New York: Plenum Press.

Gondolf, E. W., & Foster, R. A. (1991). Wife assault among VA alcohol rehabilitation patients. *Hospital and Community Psychiatry, 42,* 74-79.

Gondolf, E. W., & Russell, D. M. (1986). The case against anger control treatment programs for batterers. *Response, 9,* 2-5.

Goode, W. J. (1971). Force and violence in the family. *Journal of Marriage and the Family, 33,* 624-636.

Gorsuch, R. L. (1983). *Factor analysis* (2nd ed.). Hillsdale, NJ: Erlbaum.

Gottman, J. M. (Ed.). (1995). *The analysis of change.* New York: Erlbaum.

Gottman, J. M. (1999). *The marriage clinic: A scientifically-based marital therapy.* New York: Norton.

Gottman, J., Jacobson, N., Rushe, R. M, Short, J., Babcock, J., Taillade, J., et al. (1995). The relationship between heart rate reactivity, emotionally aggressive behavior and general violence in batters. *Journal of Family Psychology, 9,* 227-248.

Gottman, J. M., & Notarius, C. (2000). Decade review: Observing marital interaction. *Journal of Marriage and Family, 62,* 927-947.

Gottman, J. M., Notarius, C., Gonso, J., & Markman, H. (1976). *A couples guide to communication.* Champaign, IL: Research Press.

Gray, C. D., & Kinnear, P. R. (1998). *SPSS for Macintosh made simple.* East Sussex, UK: Psychology Press.

Gray-Little. B., Baucom, D. H., & Hamby, S. L. (1996). Marital power, marital adjustment, and therapy outcome. *Journal of Family Psychology, 10,* 292-303.

Green, S. L., & Hansen, J. C. (1989). Ethical dilemmas faced by family therapists. *Journal of Marital and Family Therapy, 15,* 149-158.

Greene, K., & Bogo, M. (2002). The different faces of intimate violence: Implications for assessment and treatment. *Journal of Marital and Family Therapy, 28,* 455-466.

Greenspun, W. (2000). Embracing the controversy: A metasystemic approach to the treatment of domestic violence. In P. Papp (Ed.), *Couples on the fault line: New directions for therapists* (pp. 152-175). New York: Guilford.

Groves, R. M. (1989). *Survey errors and survey costs.* New York: Wiley.

Guertin, W. H., & Bailey, J. P. (1970). *Introduction to modern factor analysis.* Ann Arbor, MI: Edwards Brothers.

Guilford, J. P. (1936). *Psychometric methods.* New York: McGraw-Hill.

Haddock, S., Zimmerman, T. S., & MacPhee, D. (2000). The power equity guide: Attending to gender in family therapy. *Journal of Marital and Family Therapy, 26,* 153-170.

Haddock, S. A. (2002). Training family therapists to assess for and intervene in partner abuse: A curriculum for graduate courses, professional workshops, and self-study. *Journal of Marital and Family Therapy, 28,* 193-202.

Hague, G., & Malos, E. (1998). *Domestic violence action for change.* London: New Clarion Press.

Halik, V., Rosenthal, D. A., & Pattison, P. E. (1990). Intergenerational effects of the Holocaust: Patterns of engagement in the mother-daughter relationship. *Family Process, 29,* 325-339.

Hamberger, L. K., & Ambuel, B. (1997). Training psychology students and professionals to recognize and intervene into partner violence: Borrowing a page from medicine. *Psychotherapy, 34*, 4.

Hamberger, L. K., Lohr, Bonge, D., & Tolin, D. F. (1996). A large-sample empirical typology of male spouse abusers and its relationship to dimensions of abuse. *Violence and Victims, 11,* 277-292.

Hansen, J. C., & Falicov, C. J. (Eds.). (1983). *Cultural perspectives in family therapy.* Rockville, MD: Aspen.

Hansen, M., Harway, M., & Cervantes, N. (1991). Therapists' perceptions of severity in cases of family violence. *Violence and Victims, 6,* 25-235.

Hanson, R. K. (1998). What do we know about sex offender risk assessment? *Psychology, Public Policy, and Law, 4,* 50-72.

Hardy, K. V. (2000, January) *Healing strained relationships.* Paper presented at the Texas Association of Marriage and Family Therapy Conference, Houston, TX. Austin, TX: Texas Association of Marriage and Family Therapy.

Hare-Mustin, R. (1986). The problem of gender in family therapy theory. *Family Process, 26,* 15-27.

Hare-Mustin, R. (1987). The problem of gender in family therapy theory. *Family Process, 33,* 19-35.

Harrell, A. J. (1991). *Evaluation of court-ordered treatment for domestic violence offenders.* Washington, DC: The Urban Institute.

Hayes, S. C. (1993). Analytic goals and the variety of scientific contextualism. In S. C. Hayes, L. J. Hayes, H. W. Reese, & T. R. Sarbin (Eds.), *Varieties of scientific contextualism* (pp. 11-27). Reno: Context Press.

Hayes, S. C., & Hayes, L. J. (1992). Some clinical implications of contextualistic behaviorism: The example of cognition. *Behavior Therapy, 23,* 225-249.

Healey, K., Smith, C., & O'Sullivan, C. (1997). *Batterer intervention: Program approaches and criminal justice strategies.* Paper presented at Meeting the Challenges of Crime and Justice: The Annual Conference of Criminal Justice Research and Evaluation, Washington, DC, July. Washington, DC: National Center for Injury Prevention and Control.

Heidegger, M. (1927/1977). *Being and time: Introduction.* In D. Krell (Ed.), *Martin Heidegger: Basic writings* (pp. 41-89). San Francisco: Harper Collins.

Heise L. (1994). Violence against women: A neglected public health issue in less developed countries. *Social Science Medicine, 39,* 9.

Heise, L., Ellsberg, M., & Gottenmoeller, M. (1999). *Ending violence against women. Population Reports Series, 1*(11), 9-18.

Holtzworth-Munroe, A., & Anglin, K. (1991). The competency of responses given by maritally violent versus nonviolent men to problematic marital situations. *Violence and Victims, 6,* 257-269.

Holtzworth-Munroe, A., Bates, L., Smutzler, N., & Sandin, E. (1997). A brief review of the research on husband violence. Part 1: Maritally violent versus nonviolent men. *Aggression and Violent Behavior, 2,* 65-99.

Holtzworth-Munroe, A., Beatty, B. S., & Anglin, K. (1995). The assessment and treatment of marital violence: An introduction for the marital therapist. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 161-172). New York: Guilford.

Holtzworth-Munroe, A., Meehan, J. C., Herron, K., Rehman, U., & Stuart, G. (2000). Testing the Holtzworth-Munroe and Stuart (1994) Batterer Typology. *Journal of and Clinical Psychology, 68,* 1000-1019.

Holtzworth-Munroe, A., Smutzler, N., Bates, L., & Sandin, E. (1996). An overview of research on couple violence: What do we know about male batters, their partners, and their children? *Psychotherapy in Practice, 2*(3), 7-23.

Holtzworth-Munroe, A., & Stuart, G. (1994). Typologies of male batterers: Three subtypes and the differences among them. *Psychological Bulletin, 116,* 476-497.

Horton, A. L. (1988). Practical guidelines for professionals working with religious spouse abuse victims. In A. L. Horton & J. A. Williamson (Eds.), *Abuse and religion: When praying isn't enough* (pp. 89-99). Lexington, MA: Lexington.

Hoshmand, L. T. (1989). Alternate research paradigms: A review and teaching proposal. *The Counseling Psychologist, 17,* 3-79.

Hoshmand, L. T. (1996). Cultural psychology and metatheory. *Journal of Theoretical and Philosophical Psychology, 24,* 30-48.

Hotaling, G. (Ed.). (1988). *Family abuse and its consequences.* Beverly Hills, CA: Sage.

Hotaling, G., & Sugarman, D. (1986). An analysis of risk markers in husband to wife violence: The current state of knowledge. *Violence and Victims, 1,* 101-124.

Huson, J. (2003). *Unemployment, access to guns among factors that turn domestic violence deadly.* Retrieved May 1, 2004, from http://www.son.jhmi.edu/newsandmedial/newsdetail.asp?ID=181

Ivey, A., Ivey, M., & Simek-Morgan, L. (Eds.). (1993). *Counseling and psychotherapy: A multicultural perspective.* Boston: Allyn & Bacon.

Jacobson, N., & Gottman, J. M. (1998). *When men batter women: New insights into ending abusive relationships.* New York: Simon & Schuster.

Jacobson, N. S., Gottman, J. M., & Shortt, J. W. (1995). The distinction between type 1and type 2 batterers—Further considerations: Reply to Ornduff et al. (1995), Margolin et al. (1995), and Walker (1995). *Journal of Family Psychology, 9,* 272-279.

Jaffe, P. G., & Geffner, R. (1998). Child custody disputes and domestic violence: Critical issues for mental health, social service, and legal professionals. In G. W. Holden, R. Geffner, & E. N. Jouriles (Eds.), *Children exposed to marital violence: Theory, research and applied issues* (pp. 371-408). Washington, DC: American Psychological Association.

Jansinski, J., & Williams, L. (1998). *Partner violence.* Newbury Park, CA: Sage.

Jenkins, A. (1990). *Invitations to responsibility: The therapeutic engagement of men who are violent and abusive.* Adelaide, Australia: Dulwich Centre.

Jenkins, C. R., & Dillman, D. A. (1997). Towards a theory of self-administered questionnaire design. In L. E. Lyberg, P. Biemer, M. Collins, E. De Leeuw, C. Dippo, N. Schwartz, & D. Trewin (Eds.), *Survey measurement and process quality* (pp. 165-196). New York: Wiley.

Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family, 57,* 283-294.

Johnson, M. P., & Ferraro, K. J. (2000). Research on domestic violence in the 1990s: Making distinctions. *Journal of Marriage and the Family, 62,* 948-963.

Johnson, S., & Lebow, J. (2000). The "coming of age" of couple therapy: A decade review. *Journal of Marital and Family Therapy, 26,* 23-38.

Jones, L. V., & Thurstone, L. L. (1955). The psychophysics of semantics: An experimental investigation. *Journal of Applied Psychology, 39,* 31-36.

Jordan, B. K., Marmar, C. R., Fairbank, J. A., Schlenger, W. E., Kulka, R. A., Hough, R. L., et al. (1992). Problems in families of male Vietnam veterans with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 60,* 916-926.

Jory, B. (2004). The Intimate Justice Scale: An instrument to screen for psychological abuse and physical violence in clinical practice. *Journal of Marital and Family Therapy, 30,* 29-44.

Jory, B., & Anderson, D. (2000). Intimate justice III: Healing the anguish of abuse and embracing the anguish of accountability. *Journal of Marital and Family Therapy, 26,* 329-340.

Kalmuss, D. (1984). The intergenerational transmission of marital aggression. *Journal of Marriage and the Family, 46,* 11-19.

Keller, J. F., Huber, J. R., & Hardy, K. V. (1988). Accreditation: What constitutes appropriate marriage and family therapy education? *Journal of Marital and Family Therapy, 14,* 297-305.

Kelly, L. (1988). *Surviving sexual violence.* Bristol: Policy Press.

Kerlinger, F. N. (1979). *Behavioral research: A conceptual approach.* New York: Holt, Rinehart & Winston.

Kerlinger, F. N. (1986). *Foundations of behavioral research* (3rd ed.). New York: Holt, Rinehart, and Winston.

Kim, J. O., & Mueller, C. W. (1978). *Introduction to factor analysis: What it is and how to do it.* Newbury Park, CA: Sage.

Klockars, A. J., & Yamagishi, M. (1988). The influence of labels and positions in rating scales. *Journal of Educational Measurement, 25,* 85-96.

Knopp, F. H. (1984). *Retraining adult sex offenders: Methods and models.* Orwell, VT: Safer Society.

Koss, M. P., Goodman, L. A., Browne, A., Fitzgerald, L. F., Keita, G. P., & Russo, N. F. (1994). *No safe haven: Male violence against women at home, at work, and in the community.* Washington, DC: American Psychological Association.

Kurz, D. (1987). Emergency department responses to battered women: Resistance to medicalization. *Social Problems, 34,* 69-81.

Langan, P. A., & Innes, C. A. (1986). *Preventing domestic violence against women.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Larson, J. H., Crane, D. R., & Smith, C. W. (1991). Morning and night couples: The effect of wake and sleep patterns on marital adjustment. *Journal of Marital and Family Therapy, 17,* 53-65.

Lebow, J. (1997). The integrative revolution in couple and family therapy. *Family Process, 36,* 1-17.

Lee, R. E. (2002). *Who is getting licensed? Report to the member states.* Colorado Springs, CO: Association of Marital and Family Therapy Regulatory Boards.

Lee, R. E., Nichols, D. P., Nichols, W. C., & Odom, T. (2004). Trends in family therapy supervision: The past 25 years and into the future. *Journal of Marital and Family Therapy, 30,* 61-69.

Leonard, K. E., Bromet, E. J., Parkinson, D. K., Day, N. L., & Ryan, C. M. (1985). Pattern of alcohol use and physically aggressive behavior in men. *Journal of Studies on Alcohol, 46,* 279-282.

Leonard, K. E., & Senchak, M. (1996). Prospective prediction of husband marital aggression within newlywed couples. *Journal of Abnormal Psychology, 105,* 369-380.

Lewis, S. F., & Fremouw, W. (2001). Dating violence: A critical review of the literature. *Clinical Psychology Review, 21*(1), 105-127.

Lewis, W., & Rohrbaugh, M. (1989). Live supervision by family therapists: A Virginia survey. *Journal of Marital and Family Therapy, 15,* 323-326.

Liddle, H. A. (1991). Empirical values and the culture of family therapy. *Journal of Marital and Family Therapy, 17,* 327-348.

Likert, R. (1932). A technique for the measurement of attitudes. *Archives of Psychology, 22,* 1-55.

Lipchik, E. (1991, May/June). Spouse abuse: Challenging the party line. *Family Therapy Networker,* 59-63.

Lipchik, E., & Kubicki, A. (1996). Solution-focused domestic violence views. In S. Miller, M. Hubble, & B. Duncan (Eds.), *Handbook of solution-focused brief therapy* (pp. 65-98). San Francisco: Jossey-Bass.

Lochman, J. E. (2000). Preventive intervention with precursors to substance abuse. In W. Bukoski & Z. Sloboda (Eds.), *Handbook for drug abuse prevention theory, science, and practice* (pp. 280-305). New York: Plenum.

Lorenz, K. (1966). *On aggression.* New York: Harcourt, Brace & World.

Los Angeles County Task Force. (1994). *Preventing domestic violence.* Los Angeles: California Attorney General's Office, Crime and Violence Prevention Center.

Luepnitz, D. (1988). *The family interpreted: Feminist theory in clinical practice.* New York: Basic Books.

Magdol, L., Moffitt, T. E., Caspi, A., Newman, D. L., Fagan, J., & Silva, P. A. (1997). Gender differences in partner violence in a birth cohort of 21 year olds: Bridging the gap between clinical and epidemiological approaches. *Journal of Consulting and Clinical Psychology, 65,* 68-78.

Maiuro, R. D., Cahn, T. S., Vitaliano, P. P., Wagner, B. C., & Zegree, J. B. (1988). Anger, hostility, and depression in domestically violent versus generally assaultive men and nonviolent control subjects. *Journal of Consulting and Clinical Psychology, 56,* 17-23.

Margolin, G. B. (1979). Domestic Conflict Scale. *Journal of Marriage and the Family, 41,* 75-88.

Martin, D. (1976). *Battered wives.* New York: Pocket Books.

McDonald, R. P. (1985). *Factor analysis and related methods.* Hillsdale, NJ: Erlbaum.

Meehan, J. C., & Holtzworth-Munroe, A. (2001). Heart rate reactivity in male batterers: Reply to Gottman (2001) and a second look at the evidence. *Journal of Family Psychology, 15,* 415-425.

Meehan, J. C., Holtzworth-Munroe, A., & Herron, K. (2001). Maritally violent men's heartrate reactivity to marital interactions: A failure to replicate the Gottman et al. (1995) typology. *Journal of Family Psychology, 15,* 394-408.

Metzloff, J. (1998). *Critical thinking about research: Psychology and related fields.* Washington, DC: American Psychological Association.

McGoldrick, M., Almeida, R., Preto, N. G., Bibb, A., Sutton, C. E., Hudak, J., et al. (1999). Efforts to incorporate social justice perspectives into a family training program. *Journal of Marital and Family Therapy, 25,* 191-210.

McGoldrick, M., Pearce, J., & Giordano, J. (Eds.). (1982). *Ethnicity and family therapy.* New York: Guilford.

Meloy, J. R. (1998). *The psychology of stalking: Clinical and forensic perspectives* (pp. 115-137). San Diego, CA: Academic Press.

Miller, I. W., Bishop, D. S., Epstein, N. B., & Keitner, G. I. (1985). The McMaster family assessment device: Reliability and validity. *Journal of Marital and Family Therapy, 11,* 345-358.

Mills, T. (1985). The assault on the self: Stages in coping with battering husbands. *Qualitative Sociology, 8,* 103- 123.

Minnesota Program Development, Inc. (2003). *The Duluth model.* Retrieved April 10, 2003, from http://www.duluth-model.org/

Monahan, J. (1984). The prediction of violent behavior: Toward a second generation of theory and policy. *American Journal of Psychiatry, 141,* 10-15.

Monahan, J. (1988). Risk assessment of violence among the mentally disordered: Generating useful knowledge. *International Journal of Law and Psychiatry, 11,* 249-257.

Monahan, J. (1992). Mental disorder and violent behavior: Perceptions and evidence. *American Psychologist, 47,* 511-521.

Monahan, J. (1993). Limiting therapist exposure to Tarasoff liability. *American Psychologist, 48*, 242-250.

Monahan, J., & Steadman, H. (Eds.). (1994). *Violence and mental disorder: Developments in risk assessment.* Chicago: University of Chicago Press.

Moon, S., Dillon, D., & Sprenkle, D. (1990). Family therapy and qualitative research. *Journal of Martial and Family Therapy, 16*, 357-373.

Mossman, D. (1994). Assessing predictions of violence: Being accurate about accuracy. *Journal of Consulting and Clinical Psychology, 62,* 783-792.

Mulvey, E. P., & Lidz, C. W. (1998). Clinical prediction of violence as a conditional judgment. *Social Psychiatric Epidemiology, 33,* S107-S113.

Murphy, C. M., & O'Farrell, T. J. (1994). Factors associated with marital aggression in male alcoholics. *Journal of Family Psychology, 89,* 321-335.

Myers Avis, J. (1996). Deconstructing gender in family therapy. In F. Piercy, D. Sprenkle, & J. Wetchler (Eds.), *Family therapy sourcebook* (2nd ed., pp. 220-225). New York: Guilford.

National Telecommunication and Information Administration. (1999). *Falling through the net : Defining the digital divide.* Retrieved May 1, 2003, from www.ntia.doc.gov/ntiahome/net2/falling.html.

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York: Guilford Press.

Neimeyer, R. (1993). An appraisal of constructivist psychotherapies. *Journal of Consulting and Clinical Psychology, 61,* 221-224.

Nelson, T. (1996). Violence against women. *World Watch, 9*(4), 33.

Nelson, T. S. (1987). *Bowen's concept of differentiation of self in clinical and nonclinical couples.* Unpublished doctoral dissertation, University of Iowa.

Nelson, T. S. (1996). Survey research in marriage and family therapy. In D. H. Sprenkle & S. M. Moon, *Research methods in family therapy* (pp. 447-468). New York: Guilford.

Nelson, T. S., & Figley, C. R. (1990). Basic family therapy skills, 2: Structural family therapy. *Journal of Marital and Family Therapy, 16,* 225-239.

Nelson, T. S., Heilbrun, G., & Figley, C. R. (1993). Basic skills in family therapy, 4: Transgenerational theories of family therapy. *Journal of Marital and Family Therapy, 19,* 253-266.

Nichols, M. P., & Schwartz, R. C. (1995). *Family therapy: Concepts and methods* (3rd ed.). Boston: Allyn & Bacon.

Nichols, W. C., Nichols, D. P., & Hardy, K. V. (1990). Supervision in family therapy: A decade restudy. *Journal of Marital and Family Therapy, 16,* 275-285.

Northey, W. F. (2002). Characteristics and clinical practices of marriage and family therapists: A national survey. *Journal of Marital and Family Therapy, 28,*487-494.

Norwicki, S. (1975). *Adult Norwicki-Strickland Internal-External Locus of Control Scale.* (Test manual available from S. Norwicki, Jr., Department of Psychology, Emory University, Atlanta, GA 30322)

O'Brien, J. E. (1971). Violence in divorce-prone families. *Journal of Marriage and Family, 33,* 692-698.

Odell, M., Shelling, G., Young, K. S., Hewitt, D. H., & L'Abate, L. (1994). The skills of the marriage and family therapist in straddling multicultural issues. *American Journal of Family Therapy, 22*(2), 145-154.

O'Leary, K. D. (1993). Through a psychological lens: Personality traits, personality disorders, and levels of violence. In R. J. Gelles & D. Loseke (Eds.), *Current controversies regarding psychological explanations of family violence* (pp. 7-30). Newbury Park, CA: Sage.

O'Leary, K. D., Barling, J., Arias, I., Rosenbaum, A., Malone, J., & Tyree, A. (1989). Prevalence and stability of physical aggression between spouses: A longitudinal analysis. *Journal of Consulting and Clinical Psychology, 63,* 256-262.

Olson, D. H. L. (1976). The family contract game: Description and effectiveness. In D. H. L. Olson (Ed.), *Treating relationships* (pp. 269-277). Lake Mills, IA: Graphic Publishing.

Olson, D. H., Portner, J. M., & Lavee, Y. (1985). *FACES III.* (Available from Family Social Science, University of Minnesota, 290 McNeal Hall, St. Paul, MN 55108)

Olson, D. H., & Ryder, R. G. (1970). Inventory of marital conflicts (IMC): An experimental interaction procedure. *Journal of Marriage and the Family, 32,* 443-448.

O'Sullivan, J. J., & Gilbert, R. K. (1989). Master's degree programs in marital and family therapy: An evaluation of admission and program requirements. *Journal of Marital and Family Therapy, 15,* 337-347.

Otto, R. K. (1992). Predicting dangerous behavior: A review and analysis of second generation research. *Forensic Reports, 5,* 103-133.

Otto, R. K. (1994). On the ability of mental health professionals to "predict dangerousness": A commentary on interpretations of the "dangerousness" literature. *Law & Psychology Review, 18,* 43-68.

Otto, R. K. (2000). Assessing and managing violence risk in outpatient settings. *Journal of Clinical Psychology, 56,* 1239-1262.

Pagelow, M. (1981). *Women battering: Victims and their experiences.* Newbury Park, CA: Sage.

Pagelow, M. D. (1984). *Family violence.* New York: Praeger.

Pagelow, M. D. (1992). Adult victims of domestic violence. *Journal of Interpersonal Violence, 7,* 87-120.

Pan, H. S., Neidig, P. H., & O'Leary, K. D. (1994). Predicting mild and severe husband-to-wife physical aggression. *Journal of Consulting and Clinical Psychology, 62,* 975-981.

Pedhazur, E. J., & Schmelkin, L. P. (1991). *Measurement, design, and analysis: An integrated approach.* Hillsdale, NJ: Erlbaum.

Pence, E., & Paymar. M. (1993). *Education groups for men who batter: The Duluth model.* New York: Springer.

Pinsof, W., & Wynne, L. (1995). The effectiveness of marriage and family therapy for a scientific theory of family therapy. *Journal of Marital and Family Therapy, 12,* 359-372.

Pleck, E. (1987). *Domestic tyranny: The making of American social policy against family violence from colonial times to the present.* New York: Oxford University Press.

Pleck, E., Pleck, J., Grossman, M., & Bart, P. (1978). The battered data syndrome: A reply to Steinmetz. *Victimology, 2,* 680-683.

Quigley, B. M., & Leonard, K. E. (1996). Desistance of husband aggression in the early years of marriage. *Violence and Victims, 11,* 366-370.

Quinn, W. H., & Davidson, B. (1984). Prevalence of family therapy models: A research note. *Journal of Marital and Family Therapy, 10,* 393-398.

Rennison, C. M., & Welchans, S. (2000). *Intimate partner violence.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Renzetti, C. M. (1997). Violence and abuse among same-sex couples. In A. Cascarelli (Ed.), *Violence between intimate partners: Patterns, causes and effects* (pp. 70-89). Boston, MA: Allyn & Bacon.

Rieker, P., & Carmen, E. H. (1986). The victim-to-patient process: The disconfirmation and transformation of abuse. *American Journal of Orthopsychiatry, 56,* 360-370.

Riggs, D., O'Leary, K., & Breslin, F. (1990). Multiple predictors of physical aggression in dating couples. *Journal of Interpersonal Violence, 5,* 61-73.

Riggs, D. S., Caulfield, M. B., & Street, A. E. (2000). Risk for domestic violence: Factors associated with perpetration and victimization. *Journal of Clinical Psychology, 56,* 1289-1316.

Rohrmann, B. (2002). *Verbal qualifiers for rating scales: Sociolinguistic considerations and psychometric data.* Melbourne, Australia: University of Melbourne. Retrieved May 1, 2003, from www.psych.unimelb.edu.au/staff/rohrman.html

Root, M. P. (1992). Reconstructing the impact of trauma on personality. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology* (pp. 229-265). New York: Guilford.

Rosen, K., & Stith, S. (1995). Women terminating abusive dating relationships: A qualitative study. *Journal of Social and Personal Relationship, 12,* 155-160.

Rosenbaum, A. (1988). Methodological issues in marital violence research. *Journal of Family Violence*, 3(2), 91-104.

Rosenbaum, A., Cohen, P., & Forsstrom-Cohen, B. (1991). The ecology of domestic aggression toward adult victims. In R. T. Ammerman & M. Hersen (Eds.), *Case studies in family violence* (pp. 39-56). New York: Plenum.

Rosenbaum, A., Hoge, S. K., Adelman, S. A., Warnken, W. J., Fletcher, K. E., & Kane, R. (1994). Head injury in partner-abusive men. *Journal of Consulting and Clinical Psychology, 62,* 1187-1193.

Rosenbaum, A., & O'Leary, K. D. (1981). Marital violence: Characteristics of abusive couples. *Journal of Consulting and Clinical Psychology, 41*, 63-71.

Rosenberg, C. S. (1985). The female world of love and ritual: Relations between women in nineteenth-century America. In C. Smith-Rosenberg (Ed.), *Disorderly conduct: Visions of gender in Victorian America* (pp. 53-76). London: Oxford University Press.

Ross, D. J., Hart, S. D., & Webster, C. D. (1998). *Facts and fates: Testing the HCR-20 against aggressive behavior in hospital and community.* Unpublished manuscript, Simon Fraser University, Vancouver, BC, Canada.

Rothwell, N. D. (1985). Laboratory and field response research studies for the 1980 census of population in the United States. *Journal of Official Statistics, 1*(2), 137-157.

Roy, M. (1977). A current study of 150 cases. In M. Roy (Ed.), *Battered women: A psychosociological study of domestic violence* (p. 25). New York: Van Nostrand Reinhold.

Rusbult, C., & Martz, J. (1995). Remaining in an abusive relationship: An investment model analysis of nonvoluntary dependence. *Personality and Social Psychology Bulletin, 21,* 558-571.

Russell, D. E. (1984). *Sexual exploitation: Rape, child sexual abuse, and workplace harassment.* Newbury Park, CA: Sage.

Salter, A. C. (1988). *Treating child sex offenders and victims.* Newbury Park, CA: Sage.

Saunders, D. G. (1992). Woman battering. In R. T. Ammerman & M. Hersen (Eds.), *Assessment of family violence: A clinical and legal sourcebook* (pp. 208-235). New York: Wiley.

Saunders, D. G. (1996). Feminist-cognitive-behavioral and process-psychodynamic treatments for men who batter: Interaction of abuser traits and treatment models. *Violence and Victims, 11,* 393-414.

Schechter, S. (1982). *Women and male violence: The visions and struggles of the battered women's movement.* Boston: South End Press.

Schlossberger, E., & Hecker, L. (1996). HIV and family therapists' duty to warn: A legal and ethical analysis. *Journal of Marital and Family Therapy, 22*(1), 27-40.

Selzer, M. L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry, 127,* 1653-1658.

Shamai, M. (1996). Couple therapy with battered women and abusive men: Does it have a future? In L. Edleson & Z. Eiskovits (Eds.), *Physical violence in American families* (pp. 507-526). New Brunswick, NJ: Transaction.

Skinner, H. A., & Sheu, W. (1982). Reliability of alcohol use indices: The lifetime drinking history and the MAST. *Journal of Studies on Alcohol, 43,* 1157-1170.

Sless, D. (1994). Public forums: Designing and evaluating forms in larger organizations. *Proceedings of Public Graphics,* 9(2-25).

Smith, T. W. (1993). *Little things matter: A sampler of how differences in questionnaire format can affect survey responses* (GSS Methodological Report No. 78). Chicago: National Opinion Research Center.

Solomon, J., Ott, J., & Roach, A. (1986). A survey of training opportunities for predoctoral psychology interns in marriage and family therapy. *Journal of Marital and Family Therapy, 12,* 260-280.

Spearman, C. (1904). "General intelligence" objectively determined and measured. *American Journal of Psychology, 15,* 201-293.

Spence, J. T., & Helmreich, R. L. (1972). The Attitudes Toward Women Scale: An objective instrument to measure attitudes towards the rights and roles of women in contemporary society. *Psychological Documents, 2,* 153.

Spence, J. T., & Helmreich, R. L. (1978). *Masculinity and femininity: Their psychological dimensions, correlates and antecedents.* Austin: University of Texas Press.

Spender, D. (1980). *Man-made language.* London: Routledge & Kegan Paul.

Sprenkle, K. H., & Bischoff, R. J. (1995). Research in family therapy: Trends, issues, and recommendations. In M. P. Nichols & R. C. Schwartz (Eds.), *Family therapy: Concepts and methods* (3rd ed., pp. 542-580). Boston: Allyn & Bacon.

SPSS, Inc. (1975). *Statistical package for the social sciences.* New York: McGraw-Hill.

Stanko, E. A. (1985). *Intimate intrusions: Women's experience of male violence.* Boston: Routledge & Kegan Paul.

Steadman, H. J. Monahan, J., Appelbaum, P. S., Grisso, T., Mulvey, E. P., Roth, L.W., et al. (1998). Designing a new generation of risk assessment research. In J. Monahan & H. Steadman (Eds.), *Violence and mental disorder: Developments in risk assessments* (pp. 297-318). Chicago: University of Chicago Press.

Stevens, J. (1996). *Applied multivariate statistics for the behavioral sciences* (3rd ed.). Mahwah, NJ: Erlbaum.

Stith, S. M., Crossman, R. K., & Bischof, G. P. (1991). Alcoholism and marital violence: A comparative study of men in alcohol treatment programs and batterer treatment programs. *Alcoholism Treatment Quarterly, 8,* 3-20.

Straus, M. A. (1973). A general systems theory approach to a theory of violence between family members. *Social Science Information, 12,* 105-125.

Straus, M. A. (1979). Measuring intra family conflict and violence: The Conflict Tactics Scale. *Journal of Marriage and the Family, 41,* 75-88.

Straus, M. A. (1986). Medical care costs of intrafamily assault and homicide. *Bulletin of the New York Academy of Medicine, 62,* 556-561.

Straus, M. A., & Gelles, R. J. (1990). *Physical violence in American families: Risk factors and adaptation to violence in 8,145 families.* New Brunswick, NJ: Transaction.

Straus, M. A., Gelles, R. M, & Steinmetz, S. K. (1980). *Behind closed doors: Violence in the American family.* New York: Anchor/Doubleday.

Straus, M. A., & Smith, C. (1990). Family patterns and primary prevention of family violence. In M. A. Straus & R. J. Gelles (Eds.), *Physical violence in American families* (pp. 507-526). New Brunswick, NJ: Transaction.

Strube, M. J. (1988). The decision to leave an abusive relationship: Empirical evidence and theoretical issues. *Psychological Bulletin, 104*, 236-250.

Stuart, G. L., & Holzworth-Munroe, A. (1994). Identifying subtypes of maritally violent men: Descriptive dimensions, correlates and causes of violence, and treatment implications. In S. Stith & M. Straus (Eds.), *Understanding partner violence* (pp. 162-163, 172). Minneapolis, MN: National Council on Family Relations.

Sturkie, D. K., & Paff Bergen, L. (2001). *Professional regulation in marriage and family therapy.* Boston: Allyn & Bacon.

Sue, D. W., & Sue, E. (1990). *Counseling the culturally different: Theory and practice* (2nd ed.). New York: Wiley.

Sugarman, D. B., & Hotaling, G. T. (1989). Violent men in intimate relationships: An analysis of risk markers. *Journal of Applied Social Psychology, 19,* 1034-1048.

Summers, R. W., & Hoffman, A. M. (2002). *Domestic violence: A global view.* Westport, CT: Greenwood Press.

Swanson, J. W. (1994). Mental disorder, substance abuse, and community violence: An epidemiological approach. In J. Monahan & Steadman (Eds.), *Violence and mental disorder: Developments in risk assessment* (pp. 101-136). Chicago: University of Chicago Press.

Swanson, J. W., Holzer, C. E., Ganzu, V. K., & Jono, R. T. (1990). Violence and psychiatric disorder in the community: Evidence from the epidemiological catchment area surveys. *Hospital and Community Psychiatry, 41,* 761-770.

Symonds, P. M. (1931). *Mental measurement of preschool children with a guide to administration of the Merril-Palmer Scale of Mental Tests.* New York: American Book Company.

Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 551 P. 2d 334, 131 Cal Rptr, 14 (1976).

Taylor, P. J., & Gunn, J. (1984). Violence and psychosis. *British Medical Journal, 288,* 1945-1949.

Thurstone, L. L. (1928). Attitudes can be measured. *American Journal of Sociology, 33,* 529-554.

Thurstone, L. L. (1947). *Multiple-factor analysis.* Chicago: Chicago University Press.

Tierney, K. (1982). The battered women's movement and the creation of the wife beating problem. *Social Problems, 29,* 207-220.

Tinsley, H. E. A., & Tinsley, D. J. (1987). Uses of factor analysis in counseling psychology research. *Journal of Counseling Psychology, 34,* 414-424.

Tollman, R. M., & Bennett, L. W. (1990). A review of quantitative research on men who batter. *Journal of Interpersonal Violence, 5,* 87-118.

Turner, W., & Shapiro, C. H. (1986). Battered women: Mourning the death of a relationship. *Social Work, 31,* 372-376.

Tweed, R., & Dutton, D. G. (1998). A comparison of instrumental and impulsive subgroups of batters, violence and victims. *Violence and Victims, 13,* 217-230.

U.S. Department of Justice. Bureau of Justice Statistics. (1984). *Intrafamilial victimization statistics.* Washington, DC: Author.

U.S. Department of Justice. Bureau of Justice Statistics. (1992). *National crime victimization survey.* Washington, DC: Author.

Vivian, D., & Malone, J. (1997). Relationship factors and depressive symptomology associated with mild and severe husband-to-wife physical aggression. *Violence and Victims, 12,* 3-18.

Walker, L. E. (1979). *The battered woman.* New York: Harper and Row.

Walker, L. E. A. (1994). *The abused woman—A survivor therapy approach: A viewer's manual.* New York: Newbridge Professional Programs.

Walker, L. E. A. (1995). Current perspectives on men who batter women—Implications for intervention and treatment to stop violence against women: Comment on Gottman et al. (1995). *Journal of Family Psychology, 9,* 264-271.

Walker, L. E. A. (1999). Psychology and domestic violence around the world. *American Psychologist, 54*(1), 21-29.

Walker, L. E. A. (2000). *Battered woman syndrome.* New York: Springer.

Walker, L. E. A., & Meloy, J. R. (1998). Stalking and domestic violence. In J. R. Meloy (Ed.), *The psychology of stalking: Clinical and forensic perspectives* (pp. 140-161). San Diego, CA: Academic Press.

Walters, M., Carter, B., Papp, P., & Silverstein, O. (Eds.). (1988). *The invisible web: Gender patterns in family relationships.* New York: Guilford.

Waltz, J. (1995). The relationship between heart rate reactivity, emotionally aggressive behavior, and general violence in batterers. *Journal of Family Psychology, 9,* 227-248.

Waltz, J., Babcock, J., Jacobson, N., & Gottman, J. (2000). Testing a typology of batters. *Journal of Consulting and Clinical Psychology, 68,* 658-669.

Warwick, D. P., & Lninger, C. A. (1975). *The sample survey.* New York: McGraw-Hill.

Watson, D., & Friend, R. (1969). Measurement of social-evaluative anxiety. *Journal of Consulting and Clinical Psychology, 33,* 448-457.

Watzlawick, P., Beavin, J., & Jackson, D. D. (1967). *Pragmatics of human communication.* New York: Norton.

Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *HCR-20: Assessment risk for violence (Version 2).* Burnaby, BC: Simon Fraser University, Mental Health, Law, and Policy Institute.

Weems, C. F. (1999). Psychological inquiry and the role of world views. *Behavior and Philosophy, 27,* 147-163.

Wessely, S., & Taylor, P. (1991). Madness and crime: Criminology versus psychiatry. *Criminal Behavior and Mental Health, 1,* 193-228.

Wetchler, J. L. (1989). Supervisors' and supervisees' perceptions of the effectiveness of family therapy supervisor interpersonal skills. *American Journal of Family Therapy, 17,* 244-256.

Wetchler, J. L., Piercy, F. P., & Sprenkle, D. H. (1989). Supervisors' and supervisees' perceptions of the effectiveness of family therapy supervisory techniques. *American Journal of Family Therapy, 17,* 35-47.

White, M. B., & Russell, C. S. (1995). The essential elements of supervisory systems: A modified Delphi study. *Journal of Marital and Family Therapy, 31,* 33-53.

Wiesz, A., Tolman, R., & Saunders, D. (2000). Assessing the risk of severe domestic violence: The importance of survivors' predictions. *Journal of Interpersonal Violence, 15,* 75-90.

Wildt, A. R., & Mazis, M. B. (1978). Determinants of scale response: Label versus position. *Journal of Marketing Research, 15,* 261-267.

Wilson, L. L., & Stith, S. M. (1993). The voices of African-American MFT students: Suggestions for improving recruitment and retention. *Journal of Marital and Family Therapy, 19,* 17-30.

Wolf-Smith, J. H., & LaRossa, R. (1992). After he hits her. *Family Relations, 41,* 324-329.

Worcester, R. M., & Burns, T. R. (1975). A statistical examination of the relative precision of verbal scales. *Journal of Market Research Society, 17,* 181-197.

Wright, P., & Barnard, P. (1975). Just fill in this form: A review for designers. *Applied Ergonomics, 6,* 213-220.

Wright, P., & Barnard, P. (1978). Asking multiple questions about several items: The design of matrix structures on application forms. *Applied Ergonomics, 9,* 7-14.

Yllo, E., & Bograd, M. (1988). *Feminist perspectives on wife abuse.* Thousand Oaks, CA: Sage.

BIOGRAPHICAL SKETCH

Marie Theresa Bracciale was born in Brooklyn, New York, July 2, 1957. She attended Catholic school for her elementary and middle school years, then moved to Florida. She has two brothers, a younger one named Dominick and an older one named Dan; she is close with both of them. Her mother, Rose, is over 82 years old and is still an avid reader; Marie feels that she learned the value of patience from her mother. Marie received her Bachelor of Science degree in health science education from the University of Florida in 1980. In 1987 she was awarded a Master of Arts in clinical holistic health education counseling from John F. Kennedy University in Orinda, California. While in California, she had a private practice in marriage and family therapy, specializing in substance abuse recovery, codependency recovery, and sexual abuse recovery She has worked in outpatient, residential, and inpatient facilities with both adolescents and adults. She enjoys teaching, coaching, and consulting. She was awarded a Doctor of Philosophy degree in counselor education, with a minor in statistics, from the University of Florida. She lives with her partner of 9 years in Deltona, Florida. She enjoys music, especially drumming, kayaking, and all beach activities. She is currently an Adjunct Professor at the University of Central Florida and is continuing her research work in relationship violence, supervising interns, and providing consultation services.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Silvia Echevarria-Doan, Chair
Associate Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Education.

Barbara Rienzo
Professor of Health Science Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

David Miller
Professor of Educational Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Education.

Peter Sherrard
Associate Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Sondra Smith
Assistant Professor of Counselor Education

This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August 2004

Dean, College of Education

Dean, Graduate School